Nebraska Department of Education
Educational Health Services

English
Referral for
Vision Examination

REFERRAL FOR VISION EXAMINATION
Report to Parents

_____
School

_____
Grade Teacher

_____
Date

_____
Student Name

_____
Parent/Guardian Name/Address

The results of vision screening at school indicate that your child may have some problem with vision and should have an eye examination.

_____

_____

_____ _____
Name Title

. . . . . .

Doctor's Report To School

Visual acuity without glasses: R _____ L _____

Visual acuity with glasses: R _____ L _____

Diagnosis _____

No glasses needed _____

Correction prescribed:
- ❑ Glasses
- ❑ Contact lens
- ❑ Change in prescription
- ❑ Consistent use
- ❑ Close work use
- ❑ Distance vision use

Comments or suggestions as to specific needs for child's school program (equipment, seating):

_____

Please return this report to the school at:

_____
Physician's Signature Date

_____ _____
Address Phone

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