VISION REFERRAL LETTER

Student Name | Birthdate | School | Grade
---|---|---|---

School Nurse | Phone Number | Date

Dear Parent:
State law requires that students who are unable to pass vision screening be referred for a professional eye exam. A student with uncorrected visual acuity is at a disadvantage for learning. Here are the results of the recent vision screening.

<table>
<thead>
<tr>
<th>Without Glasses</th>
<th>With Glasses/Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>RE</td>
<td>LE</td>
</tr>
</tbody>
</table>

Distance Vision

Near Vision

Comments

Ophthalmologist/Optometrist Exam:

<table>
<thead>
<tr>
<th>Without Correction</th>
<th>With Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>RE</td>
<td>LE</td>
</tr>
</tbody>
</table>

Distance

Near

Glasses Prescribed: □ Yes □ No

Glasses should be worn: □ Distance □ Work Near Work □ At all times

Other recommendations: ___________________________

Student should return ___________________________

Doctor's stamp: 

Please fax completed form to: 

Doctor's Signature | Date

Parent’s Signature (Permission to send form) | Date