Ohio Department of Health
Eye Specialist Report

School Screening Information

Child's Name	Date of Referral
School	Grade
Reason for referral (test failed or type of symptom)	

School Screening visual acuity	**without glasses**	**with glasses**
	R_____ L_____	R_____ L_____

Eye Specialist

Distance Visual Acuity	**without correction**	**with current prescription**	**with new prescription**
	R_____ L_____	R_____ L_____	R_____ L_____

Summary of vision problems and diagnosis

_____

_____

_____

Recommendations

Additional instructions for teacher

_____

_____

_____

Is further treatment necessary? ☐ Yes ☐ No	I wish to see the child again. ☐ Yes ☐ No
If yes, specify	If yes, when?

Please return form to

From

	Eye Specialist		
	Address		
	City	State	ZIP
	Date		

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