Recommended but not required

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) Evaluation prior to school entry	
School Screening visual acuity — **without glasses** R___________ L___________ **with glasses** R___________ L___________	

Eye Specialist

Distance Visual Acuity — **without correction** R___________ L___________ **with current prescription** R___________ L___________ **with new prescription** R___________ L___________

Summary of vision problems and diagnosis

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Recommendations

Additional instructions for teacher

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

Please return form to	From		
Kayla Davis, RN	Eye Specialist		
River View Local Schools	Address		
26546 State Route 60 Warsaw, OH 43844	City	State	ZIP
FAX: 740-824-5241	Date		

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