SAINT PAUL SCHOOL

Principal: Kathleen Norris, Ph.D.
61 Moss Road, Westerville, Ohio 43082 Phone: 614.882.2710 Fax: 614.882.5998

Vision Screening Referral Report

Date: _____

To the Parents of _____ D.O.B. _____

School _____ Grade _____

Vision screening was recently conducted at your child's school. The results of the vision screening indicate your child may have a vision problem. Vision problems can place your child at risk for learning difficulties. It is recommended that you take your child to his/her optometrist or ophthalmologist for further evaluation. If you have any questions concerning the screening results, please contact the school nurse. Please let the school nurse know if your child is already under a doctor's care for vision problems or if you need assistance in finding a medical provider. **Please return the completed Eye Specialist Report form on the back of this letter to the school.**

Sincerely,

Betsy Johnson

Betsy Johnson, M.S., R.N.

Consent and Release of Information

I, _____ (parent/guardian) of the above named child, hereby authorize the provider completing this report to return this completed form to:

Mrs. Betsy Johnson, M.S.,R.N.
School Nurse
St. Paul School
61 Moss Rd.
Westerville, OH 43082

For the specific purpose of notifying the school of any specific vision problems, recommendations and instructions for teachers related to the child's vision problems. This authorization expires upon submission of the completed form to the above named school.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment for services or eligibility for benefits for my child; however, if this form is not submitted to the school, I understand that the school may not have sufficient information to address special vision needs for my child.

_____ _____

(Signature of parent/guardian) *(Date)*

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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** 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			
Recommendations			
Additional instructions for teacher			
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**		
Mrs. Betsy Johnson, M.S., R.N. School Nurse	Eye Specialist		
St. Paul School	Address		
61 Moss Rd.	City	State	ZIP
Westerville, OH 43082	Date		