

**ELMONT UNION FREE SCHOOL DISTRICT
SCHOOL HEALTH SERVICE
ELMONT, NEW YORK**

PARENT NOTIFICATION REGARDING VISION

Student's Name: _____ Date: _____
School: _____ Grade: _____ Teacher: _____

TO THE PARENT OR GUARDIAN:

A recent evaluation indicates that your child may have some eye difficulty. A complete eye examination, by an ophthalmologist is recommended. This completed form should be returned to the school nurse as soon as possible.

TO THE EXAMINER:

The following signs of difficulty have been noted by school personnel:

Your diagnosis and recommendations will help in planning for this child's school program.

Principal

School Nurse

REPORT OF EYE SPECIALIST:

1. Diagnosis: R _____ L _____
2. Visual Acuity: Distance (a) Without Correction R _____ L _____
(b) With Correction R _____ L _____
Visual Acuity: Near (a) Without Correction R _____ L _____
(b) With Correction R _____ L _____
3. Plan (*check one*): () No treatment at this time () Eyeglasses () Contact Lenses: Both, R or L
() Patch: Both, R or L () Other: _____
4. Under what conditions should glasses, patch or contact lens be worn?

5. Have shatterproof lenses been recommended? () No () Yes: _____
6. When should this student be re-examined? _____
7. Recommendation, Remarks and Accommodations/Limitations in School/Gym/ Playground:

ADDITIONAL INFORMATION REGARDING THE CHILD WHO HAS A VISUAL DIAGNOSIS:

1. Has the child been examined for low vision lenses? () Yes: _____ () No: _____
2. Peripheral vision: R _____ L _____
If the fields are restricted, indicate degree and location:

3. Should physical activities be limited because of eye condition? () No () Yes
If yes, please specify:

Date of Examination

Examiner's Signature and Title