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

PARENT NOTIFICATION FOR RECOMMENDED RE-EXAMINATION OF THE CHILD'S EYES

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

TO THE PARENT OR GUARDIAN
The last report received from your eye specialist indicates that your child is due to have his/her eyes re-examined. Please have this form completed and return it to the school nurses.

_____ _____
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*

_____
Address/Telephone

SHS #15 Revised 12/97. 5/06. 5/07.

*****PLEASE INCLUDE SIGNATURE AND STAMP*****