

**MARPLE NEWTOWN SCHOOL DISTRICT  
 NEWTOWN SQUARE, PENNSYLVANIA 19073  
 HEALTH SERVICES DIVISION  
 Vision Referral**

Date \_\_\_\_\_

Dear Parent/Guardian:

A recent vision screening test given in school has indicated that your child may have a vision problem which requires attention. We recommend that your child have an examination by an eye specialist.

Please request that the eye specialist complete the form below and return it to your child's School Nurse. If your child is under the care of an eye specialist, please have this form completed for your child's school health records. Thank you.

Forgot glasses \_\_\_\_\_ School Nurse \_\_\_\_\_  
 Broken glasses \_\_\_\_\_ School \_\_\_\_\_  
 Phone \_\_\_\_\_

EYE EXAMINATION REPORT

Student's Name: \_\_\_\_\_ Date examined: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_

Visual acuity without lenses Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_  
 with lenses Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_

Diagnosis \_\_\_\_\_

Glasses Prescribed Yes \_\_\_\_\_ No \_\_\_\_\_

For Constant Wear Yes \_\_\_\_\_ No \_\_\_\_\_

Special seating in the classroom advisable? Yes \_\_\_\_\_ No \_\_\_\_\_

Recommendations \_\_\_\_\_

---

Eye Specialist's Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Phone \_\_\_\_\_