ARLINGTON PUBLIC SCHOOLS
EDUCATE • PREPARE • INSPIRE

Recommendation for Eye Exam

Date

DEAR PARENT/GUARDIAN OF:

A recent eye screening at school indicates that your child may have some difficulty with vision. This letter is to request that you schedule an eye exam with an optometric physician or optometrist.

Please have this form with you at the time of the examination and return it to your child's school health room with the results from the optometrist or eye physician.

If financial assistance is needed to complete the exam, please contact your child's school health room.

Health Room Specialist

TO EYE EXAMINER:
We are referring this student to you for the following reason(s):

☐ Failed the Instrument-Based Vision Screening Device Date Tested with glasses: ☐ Yes ☐ No

☐ Myopia *(Nearsightedness)* ☐ Hyperopia *(Farsightedness)* ☐ Asymmetry *(Uneven eyes)* ☐ Amblyopia *(Lazy eye)* ☐ Gaze Symmetry *(Eyes look in different directions)* ☐ Astigmatism *(Blurred vision)*

☐ Anisometropia *(Unequal refractive power)* ☐ Strabismus *(Eye misalignment)* ☐ Anisocoria *(Unequal pupil size)* ☐ Refractive Error *(Problem focusing eye shape)* ☐ Visual Acuity *(Clarity of vision)*

☐ Signs or Symptoms of Visual Problems:

REPORT FROM EYE EXAMINER TO SCHOOL:

Visual Acuity
A) Without Correction Right: 20/ Left: 20/ B) With Correction Right: 20/ Left: 20/

Corrective Lenses: ☐ Not Prescribed ☐ Prescribed To be worn when?

Special Accommodations?

Diagnosis and/or etiology:

Comments:

Follow up:

Eye Examiner's Signature Date

Printed Name: