VISION REFERRAL LETTER

Florida Department of Health
School Health Services Program

NAME: _____ GRADE: _____ DOB: _____

DATE:_____ SCHOOL: _____

FAMILY DOCTOR: _____PHONE NUMBER: _____ FAX NUMBER: _____

Dear Parent/Guardian:
A vision screening was conducted for your child at school. The result of your child's screening (listed on the reverse side) indicates a *possible* vision problem. We strongly suggest that you take your child to an eye doctor (ophthalmologist or optometrist) for a complete eye exam as soon as possible.

We believe your child will benefit by giving this matter your attention. Untreated eye and vision problems can affect your child's general health and performance in school.

If you are concerned about getting your child an eye exam for any reason, *WE CAN HELP!* No-cost eye exams and glasses may be available through the school district or health department. Contact your child's school clinic or call _____ for assistance, if needed.

Here's what you need do:

1. Schedule an eye appointment with an eye doctor.
2. Sign the consent and release of information at the bottom of this page.
3. Bring this form to an eye doctor to complete the reverse side.
4. Return this completed form to the school clinic so your child's health record can be updated.

If your child is currently under the care of an eye doctor, or if you are already aware of a vision problem, or if you do not plan on taking your child for further testing, please explain:

_____
_____
_____
_____
_____

Consent and Release of Information:
By my signature below, I authorize: (1) the vision screening agency to release my child's vision screening results and/or medical or developmental reason for an eye exam to the eye doctor and medical doctor (if screening did not occur in the medical home), (2) my child's eye doctor to send exam results to the vision screening agency, (3) the vision screening agency and eye doctor to discuss eye exam results, (4) and the vision screening agency to send exam results to the child's medical doctor (if screening did not occur at the medical office) for the specific purpose of notifying my child's healthcare and educational providers of any specific vision problems, recommendations, and treatment instructions related to my child's vision needs. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain an eye exam for my child or assistance with payment for the eye exam.

Parent/Guardian Signature: _____Date: _____

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TO BE COMPLETED BY SCHOOL STAFF:

VISION SCREENING RESULTS:

Visual screening tool used: (Check One)

LEA SYMBOLS®_____ HOTV_____ Sloan Letters _____ Spot _____ Plusoptix _____

Other: _____

Pass: _____ **Fail**: _____

Visual acuity: Right Eye 20 /_____ Left Eye 20 /_____

Screened: **(Check One)** With glasses _____ Without glasses_____

_____Automated screening was performed and a printout of the results is attached.

TO BE COMPLETED BY THE EYE DOCTOR:

***Please share exam results with student's primary care physician**

COMPREHENSIVE EYE EXAM RESULTS:

Best Corrected Visual acuity: Right eye _____ Left eye _____

Report of examination: **Glasses/Contacts Prescribed:** Yes _____ No _____

When should glasses/contacts be worn?

_____

Doctor's Diagnosis/Recommendations:

_____

_____

_____

Doctor Signature: _____ **Date:** _____

Office Phone Number: _____ **Fax Number:** _____

(May 2018)