Ohio Department of Health
Eye Specialist Report

School Screening Information

Child's Name

Date of Referral

School

Grade

Reason for referral (test failed or type of symptom)

School Screening visual acuity

without glasses: R ________ L ________

with glasses: R ________ L ________

Eye Specialist

Distance Visual Acuity

without correction: R ________ L ________

with current prescription: R ________ L ________

with new prescription: R ________ L ________

Summary of vision problems and diagnosis

Recommendations

Additional instructions for teacher

Is further treatment necessary? ☐ Yes ☐ No

If yes, specify

I wish to see the child again. ☐ Yes ☐ No

If yes, when?

Please return form to

From

Eye Specialist

Address

City

State

ZIP

Date

HEA 4713 (Rev 11/97)