DISTRITO ESCOLAR UNIFICADO DE POMONA **VISION**

Servicios de Salubridad y Programas
Recommendacion para la Evaluacion Medica

LLEVE ESTA FORMA A SU DOCTOR

Alumno(a):_______________________________ Grado:________

Escuela:__________________________

Estimado Padres/Guardián:

Como resultado de pruebas de examenes recientes en la escuela, su niño(a) require un examen por un oculista. Se recomienda que un especialista de vista evalue a su niño(a). Si requiere ayuda financiera para obtener un examen de ojo , favor de comunicarse con su enfermera escolar al 397-_________________.

Fecha: ________________ Enfermera: ____________________________

Note to Examiner:

This referral is based on a vision-screening test. Thank you for returning this form to facilitate the educational process.

Vision (FP)_____ _____ (NP) _____ _____
Right Left Right Left

W/Glasses (FP)_____ _____ (NP) _____ _____
Right Left Right Left

Comments: _________________________________

IF MAILED:
School _________________________
Address ________________________
____
Phone __________________________
Attn: School Nurse

EXAMINER'S REPORT TO SCHOOL

This student was examined on ___________________.

Findings indicate ____

Preferential seating recommended: Yes _____ No _____

Glasses Yes _____ No _____

Student is scheduled for further evaluation on ____

Recommendations/comments: ____

Parent signature for release of information: ____

PLEASE PRINT

Doctor's Name: ________________________________ Signature: _________________________

Address: ____ Date: _____________________

Phone: __________________________

Please return to school nurse when completed by doctor.

Revised 7/17