California State Department of Education
Capitol Mall Sacramento, CA 95814

Annual Report of Vision Testing

IMPORTANT Please read the information and Report Form Definitions before completing this form.
Return completed form to: Health Services

School District	Superintendent	School
Number and Street	City	Zip Code Country
Period Covered From To	Prepared by Title	Telephone (include area code)

RESULTS OF SCREENING

(Include pupils in gifted and remedial speech classes in regular grades)

Grade Level	Enrollment In Each grade Screened	Total number of Pupils Screened	Number Of pupils Re-screened	Number of Pupils referred For professional Examination	Number of Pupils referred Actually under professional Care	Color Vision (boys) Number Tested	Color Vision (boys) Number Failed
K							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
TOTAL							

Persons authorized to Test vision	Initial screening conducted by:	Re-screening conducted by:	Follow-up conducted by:
Credentialed School Nurse			
Doctor			
Doctor of Optometry			
Teacher (trained as required)			
Public Health Department			
Other (specify)	____________	___________	___________

Criteria used for referral for visual acuity - far point:

Children age five and under 20/50 or worse

Children age six and over 20/40 or worse

Type of Test:

K-8 ___________ Snellen

Modified clinical technique ______________

SECTION 7

Revised 2/14