POMONA UNIFIED SCHOOL DISTRICT

VISION

Health Services & Programs
Referral for Vision Evaluation

TAKE THIS FORM TO YOUR DOCTOR

Student: ________________________________ Grade:________

School: _________________________

Dear Parent/Guardian:

As a result of recent school screening tests, your child requires an examination by a professional. It is recommended that an eye specialist evaluate your child. If you need assistance, please notify your school nurse at 397-___________

Date: _______________ School Nurse: ___________________________

Note to Examiner:

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

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

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