**VISION SCREENING FORM**

STUDENT’S NAME SCHOOL YEAR

SCHOOL GRADE

INITIAL EXAMINER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**KEY: P = PASS F = FAIL**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SCREENING DATE: | | | RECHECK DATE: | |
|  | FAR | NEAR | FAR | NEAR |
| BOTH EYES |  |  |  |  |
| RIGHT EYE |  |  |  |  |
| LEFT EYE |  |  |  |  |

Examiner: Examiner:

Instrument used: Instrument used:

REMARKS: REMARKS:

[ ] Within Normal Limits [ ] Within Normal Limits

[ ] Needs Recheck [ ] Needs Recheck

[ ] With Glasses [ ] With Glasses

[ ] Needs Referral [ ] Needs Referral

Resolution of Problem:

If the child cannot be conditioned to traditional vision screening, a functional vision screener may be used.

Date:

[ ] Pass [ ] Fail

Examiner:

Optional Form for Required Procedure/Evaluation.