

SCHOOL VISION REFERRAL

CHILD'S NAME _____ GRADE _____

SCHOOL _____ TEACHER _____

Dear Parent:

Your child's eyes were screened by the school nurse as one of the health services provided by this school. The results of the screening test indicate the need for a more complete eye examination. The nurse's findings are attached to this letter.

Since poor vision can affect learning, it is important to complete this referral.

Please select ONE of the options below:

- ☐ **Option A: I will take my child for an exam.** Take the attached form with you when you take your child for the examination. Return this letter, the attached form, and the eye exam results to me at the school.
- ☐ **Option B: My child is already receiving eye care.** If your child is already receiving eye care from a doctor, please let me know the date your child was last seen.
- ☐ **Option C: I/We disagree with the need and do not wish my/our child to have an eye exam.** If you wish to not have your child examined by an eye doctor, please make a note of that on this form and return the form to me at the school.

If finances are a concern and you do NOT have insurance, or need help in getting the eye exam, please call me at _____. Financial assistance may be available through various agencies.

THANK YOU FOR KEEPING YOUR CHILD HEALTHY

Parent(s) Signature _____ Date _____