

**VISION TESTING REPORT TO PARENTS**  
**(Report from Examiner)**

**To:** \_\_\_\_\_ **Date** \_\_\_\_\_

Dear Parent,

Your child, \_\_\_\_\_ did not pass a vision screening test given at Charleroi Area School District. We recommend that your child have an eye examination.

Please request the eye examiner to complete the form below and return it to me, the School Nurse.

If your child has had a recent eye examination, please request that the examiner record the results on this form for return.

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Address

**REPORT OF EYE EXAMINATION**

Name \_\_\_\_\_ Date of Examination \_\_\_\_\_

School \_\_\_\_\_

\_\_\_\_\_  
Examiner

\_\_\_\_\_  
Address

Home Address \_\_\_\_\_

Visual Acuity: Without Lenses R.E. \_\_\_\_\_ L.E. \_\_\_\_\_ Both \_\_\_\_\_  
With Lenses R.E. \_\_\_\_\_ L.E. \_\_\_\_\_ Both \_\_\_\_\_

Glasses prescribed Yes \_\_\_\_\_ No \_\_\_\_\_ For Constant Wear Yes \_\_\_\_\_ No \_\_\_\_\_

If Glasses were Prescribed. Prescription attached \_\_\_\_\_ Given to Child \_\_\_\_\_ Parent \_\_\_\_\_

If special seating in the classroom desired? Yes \_\_\_\_\_ No \_\_\_\_\_

Should child return for further care or examination? Yes \_\_\_\_\_ No \_\_\_\_\_

If answer is yes, please state reasons and suggestions \_\_\_\_\_

Other Recommendations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Examiner