VISION SCREENING FORM

Student's Name _____ School Year _____

School _____ Grade _____

Initial Examiner _____ Date _____

Screening Date: _____

	FAR	NEAR
Both Eyes	[ ] Pass [ ] Fail	[ ] Pass [ ] Fail
Right Eye	[ ] Pass [ ] Fail	[ ] Pass [ ] Fail
Left Eye	[ ] Pass [ ] Fail	[ ] Pass [ ] Fail

Examiner: _____

Instrument used: _____

Remarks:

[ ] Within Normal Limits
[ ] Needs Recheck
[ ] With Glasses
[ ] Needs Referral

Recheck Date: _____

	FAR	NEAR
Both Eyes	[ ] Pass [ ] Fail	[ ] Pass [ ] Fail
Right Eye	[ ] Pass [ ] Fail	[ ] Pass [ ] Fail
Left Eye	[ ] Pass [ ] Fail	[ ] Pass [ ] Fail

Examiner: _____

Instrument used: _____

Remarks:

[ ] Within Normal Limits
[ ] Needs Recheck
[ ] With Glasses
[ ] 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