Dayton Public Schools
OFFICE OF THE SCHOOL NURSE

Child's Name	Date of Referral
School	Grade
Reason for referral (test failed or type of symptom)	
School Screening Visual Acuity R ________________ L ________________	

Eye Specialist

Visual Acuity with old glasses R ________________ L ________________ with new glasses R ________________ L ________________ without glasses R ________________ L ________________	
Summary of vision problems and diagnosis	
Recommendation	
Recommendation for teacher	
Additional treatment necessary? ☐ Yes ☐ No	I wish to see the child again ☐ Yes ☐ No
Comments	

Return form to:

	Specialist
	Address
	Date

Health Services 1/25/07

Dayton Public Schools
OFFICE OF THE SCHOOL NURSE

VISION REFERRAL LETTER

____
DATE

Student's Name: ____

School: ____

Dear Parent/Legal Guardian:

The vision screening given at school indicates a **complete vision examination** would be **advisable** for the student named above. We are, therefore, **suggesting** that you take your child to a vision specialist for a thorough vision examination.

If you are in need of further information, contact your local school district or health department.

Please give the enclosed form to your vision specialist for completion and return it to:

____

____

____

RN:ec
Enclosure
HEA 4708