SOUTH HUNTINTON UNION FREE SCHOOL DISTRICT
Huntington Station, New York
Student Services/Department of Health Services

VISION SCREENING

Date: _____

Student's Name _____ Date of Birth _____

Address _____ Teacher/Grade _____

( ) Your child has had a recent vision screening that indicates a need for further evaluation.

( ) May we have the results of the most recent vision examination.

Pat Geyer
Principal's Signature

Karen Jacobsen RN
Signature of School Nurse

Long Island School for the Gifted
School

631-423-3557
Telephone Number

REPORT OF EYE SPECIALIST:

1. Diagnosis: R _____ L _____

2. Visual Acuity: Far: (a) Without Correction R _____ L _____ Far: (b) With Correction R _____ L _____

   Near: (c) Without Correction R _____ L _____ Near: (d) With Correction R _____ L _____

3. Under what conditions should glasses be worn? _____

4. When should this student be re-examined? _____

5. Recommendations and remarks: _____

_____

ADDITIONAL INFORMATION REGARDING THE CHILD WHO HAS A VISUAL HANDICAP:

1. Has the child been examined for low vision lenses? Yes _____ No _____

2. Peripheral vision: R _____ L _____

   If fields are restricted, indicate degree and location: _____

3. Have contact lenses been prescribed: Yes _____ No _____

4. Should the child's educational program or physical activities be modified because of the eye condition or treatment regimen? Yes _____ No _____

   If yes, please specify recommended modification: _____

_____

_____
Physician's Name (Please print)

_____
Physician's Signature

_____
Address

_____
Telephone Number

_____

_____
Date of Examination

10/19/18