VISION SCREENING RECORD OF REFERRAL AND FOLLOW-UP

School Year _____ - _____

District: _____

Child	**DOB**	**Eye Exam Referral** **YES/NO DATE**	**Date of Eye Exam**	**Eye doctor's report:** Indicate acuity: with (W) or without (W/O) glasses, if known		**Treatment** **Glasses** **YES/NO**	**Other Medical Findings**	**Treatment** **Medical/ Surgical**	**Vision Related Impact on Learning YES/NO**	**Referral date for VI evaluation**
				Left Eye	Right Eye					
				20/	**20/**					
				20/	**20/**					
				20/	**20/**					
				20/	**20/**					
				20/	**20/**					