

MARPLE NEWTOWN SCHOOL DISTRICT
NEWTOWN SQUARE, PENNSYLVANIA 19073
HEALTH SERVICES DIVISION
Vision Referral

Date _____

Dear Parent/Guardian:

A recent vision screening test given in school has indicated that your child may have a vision problem which requires attention. We recommend that your child have an examination by an eye specialist.

Please request that the eye specialist complete the form below and return it to your child's School Nurse. If your child is under the care of an eye specialist, please have this form completed for your child's school health records. Thank you.

Forgot glasses _____

School Nurse _____

Broken glasses _____

School _____

Phone _____

EYE EXAMINATION REPORT

Student's Name: _____ Date examined: _____

School: _____ Grade: _____ Homeroom: _____

Visual acuity without lenses Right _____ Left _____ Both _____

with lenses Right _____ Left _____ Both _____

Diagnosis _____

Glasses Prescribed Yes _____ No _____

For Constant Wear Yes _____ No _____

Special seating in the classroom advisable? Yes _____ No _____

Recommendations _____

Eye Specialist's Signature

Print Name

Phone