Clarksville Montgomery County School System
HEALTH SERVICES
VISION REFERRAL

Name _____ Date _____
Grade _____ Teacher _____

Dear Parent:
I hope this letter finds you well. Your child recently underwent a vision screening as mandated by the State of Tennessee. Our digital screener has indicated that a follow-up examination by your child's eye doctor is recommended. The bottom portion of this letter includes a form for your child's eye doctor to complete. Please ensure that it is filled out during the examination and promptly returned to the school nurse.

Tested: With Correction ☐ **Without Correction** ☐

Visual Acuity: ☐ Digital Screener (Spot Vision)

Grade 2 ONLY: ☐ Failed Color Perception Screening

Date of examination _____ School Nurse _____

This form should be completed by the examining physician and **returned to the school nurse.**

Diagnosis: _____

Without Correction: Right Eye 20/ Left Eye 20/

With Correction: Right Eye 20/ Left Eye 20/

Please indicate where applicable:
_____ No Corrective lenses at this time
_____ Corrective lenses_ Fulltime wear including gym activities
_____ Corrective lenses_ Fulltime wear excluding gym activities
_____ Corrective lenses_ For all academic work
_____ Corrective lenses_ For distance academic work only (blackboard, movies)
_____ Other
Should activities be limited because of eye conditions? _____Yes _____No

Recommendations and remarks_____

Re-evaluation of this patient has been recommended in: _____ Months _____ Year

_____ _____
Print or Type Name of Licensed Ophthalmologist or Optometrist Signature of Licensed Ophthalmologist or Optometrist

_____ _____
Address Date of Examination

_____ _____ _____
City State Zip Telephone Number Fax Number