Form: J

Ohio Department of Health

Eye Specialist Report

(* Return completed report to school health clinic or nurse)

School Screening Information

Child's Name: Date of Birth: Date of Referral:

School: Grade:

Reason for referral (Test failed or type of symptoms):

[ ] Failed Observation [ ] Failed Distance Visual Acuity: ☐R ☐L [ ] Failed Stereopsis [ ] Unable to screen

Circle option selected (Sloan Chart, LEA Symbols Chart 5 or 10 feet, JAEB Screener JVAS) (PASS 2 or Random Dot E)

Electronic screening:

without glasses (WA SureSight® / Retinomax) With glasses (WA SureSight® / Retinomax)

R_____ L_____ R_____ L_____

Eye Specialist Findings

Data of Exam:_____ without correction with current prescription with new prescription

[ ] Normal R_____ L_____ R_____ L_____ R_____ L_____

Summary of vision problem & diagnosis

[ ] Hyperopia: Indicate eye? _____ [ ] Myopia: Indicate eye? _____

[ ] Amblyopia: Indicate eye? _____ [ ] Strabismus: Indicate eye? _____

[ ] Esotropia: Indicate eye? _____ [ ] Astigmatism: Indicate eye? _____

[ ] Exotropia: Indicate eye? _____

[ ] Other: Explain _____

Recommendations & Treatment

Glasses Prescribed: [ ] No [ ] Yes ➡ [ ] Constant Wear [ ] Near vision only [ ] Far vision only [ ] May remove for physical education

[ ] Medical /surgical treatment (e.g., patching, Atropine drops, etc.): _____

[ ] Contact Lenses _____

Additional instructions for teachers

Upon completion of any needed eye care treatment, I expect there will be:

[ ] No significant visual problem that may interfere with learning.

[ ] Visual problem that may interfere with learning. Explain (see blow): _____

* [ ] Preferential seating needed [ ] Visual aids [ ] Magnifiers [ ] Assistive technology [ ] Lighting conditions [ ] Other: _____

Is further treatment necessary? [ ] No [ ] Yes If yes, specify_____

Do you wish to see this child again? [ ] No [ ] Yes If yes, specify _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____ _____

Parent or Guardian Signature Date

Send completed report by medical professional to:

(Place school name, address, fax #, etc. here.)

_____ _____

Eye Specialist Signature **Date**

_____

Address

_____

City State Zip

_____

Phone Number