

EYE REPORT AND RECOMMENDATIONS

*OSIS # _____ - _____ - _____

(Please print on hard surface)

| | | | | | |
|--------------------|----------|---------------------|-------------|---|--|
| CHILD'S LAST NAME: | | CHILD'S FIRST NAME: | | DATE OF BIRTH | |
| SCHOOL # | DISTRICT | BOROUGH | GRADE/CLASS | SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female | |

*Date of issue: _____ *Issued by: _____ *Title: _____

*Reason for issue: _____

TO THE PARENT: Your child did not pass one or more parts of the vision screening. Please take your child to an eye doctor for an eye examination.

SCREENING RESULTS:

Date of screening: _____ Team code: _____ **Note: 20/40 and up equals Fail**

| FAR VISION | | | NEAR VISION | |
|-----------------|--------------|-----------|-----------------|--------------|
| Without glasses | With glasses | | Without glasses | With glasses |
| 20/ | 20/ | Right eye | | |
| 20/ | 20/ | Left eye | | |
| 20/ | 20/ | Both eyes | 20/ | 20/ |

Flipper test right eye (+2.50): Pass Fail Fusion: Pass Fail

Flipper test left eye (+2.50): Pass Fail Color test: Pass Fail

*TO THE EYE DOCTOR: Please fill out all fields, especially the fields marked with a red asterisk. **

EYE DOCTOR'S EXAMINATION:

*Date of examination: _____ *Next visit: (in months) _____

*Diagnosis:

| | Right Eye | Left Eye | Both Eyes |
|----------|--------------------------|--------------------------|--------------------------|
| 1) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*Does this child have a color-perception deficiency? Yes No

Your treatment recommendations:

*Are glasses to be worn? Yes No

*When worn? (Check all that apply):
 For near only Fulltime in class **All the time**
 For far only For class and homework
 For near and far tasks At child's discretion

*New prescription Yes No

*Does/will the child wear contact lenses? Yes No

*Was child referred to another doctor or facility? Yes No

If yes, why? _____

Amblyopia therapy (if indicated)

*Is patch prescribed for use in school? Yes No If yes, in which eye? Right Left Alternating
 For how many hours per day in school? _____

*Are blurring drops prescribed? Yes No

| | Uncorrected | | Corrected | |
|-------|-------------|------|-----------|------|
| | Far | Near | Far | Near |
| Right | | | | |
| Left | | | | |
| Both | | | | |

Prescription given:

| | Sphere | Cylinder | Axis | Add |
|-------|--------|----------|------|-----|
| Right | | | | |
| Left | | | | |

PD _____

School accommodations requested:

Special vision services recommended? Yes No If yes, describe _____

Seating accommodation requested (for children with vision diagnoses only): Yes

Any front seat

| | | |
|-------------------------------------|---|--------------------------------------|
| Front left <input type="checkbox"/> | Blackboard Front center <input type="checkbox"/> | Front right <input type="checkbox"/> |
|-------------------------------------|---|--------------------------------------|

Exclude from contact sports? Yes No If yes, until _____

Should child wear glasses in gym/sports? Yes No Sports goggles required? Yes No

*Doctor's last name: _____ *First name: _____ *Specialty: _____

*Facility name: _____

*Address: _____ City: _____ State: _____ Zip: _____

*Phone #: (____) _____ *License #: _____ *Email address (at least once) _____

For additional information, please call: 347-396-4747 (Español) or 347-396-4721 (English)

PLEASE SEND ALL COMPLETED FORMS TO:

**School Health Vision Program
42-09 28th Street, Box 25
Queens, NY 11101-4132**

If you have questions about the form, please call one of the following numbers:

**347-396-4747 (Espanol)
347-396-4759
347-396-4721**

If your child has very low vision, he or she may be eligible for special services provided by the New York City Department of Education.

Educational Vision Services

The New York City Public Schools provide specialized educational services for students who are blind or visually impaired. Students are eligible if their best-corrected vision in the better eye is 20/70 or lower, or if they have specified visual impairments, such as macular degeneration, retinopathy of prematurity, optic atrophy, high myopia or albinism. Services are designed to give students access to the general curriculum, and to participate in general or special education classes at the highest possible level of independence. Available services include:

- Braille
- Large print reading materials
- Training with low vision devices
- Specialized adaptive computer technology
- Instruction in other skills to attain literacy in:
 - reading
 - writing
 - mathematics
 - sciences
 - computers
- Instruction in orientation and mobility for independence in travel
- Bus transportation, if needed.

For further information contact:

**Educational Vision Services
400 First Avenue, 7th Floor
New York, NY 10010**