

EYE REPORT AND RECOMMENDATIONS

(Please print on hard surface)			*OSIS # _____ - _____ - _____	
CHILD'S LAST NAME		CHILD'S FIRST NAME		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
DISTRICT	BOROUGH	SCHOOL		DATE OF BIRTH
				GRADE/CLASS

*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 examination.

SCREENING RESULTS

Note: 20/40 or higher fails

Reason for Pre-K Referral

Date of screening: _____ Team code: _____

Refractive Alignment Pupils

FAR VISION		NEAR VISION		
Without	With glasses	Right	Without	With glasses
20/	20/			
20/	20/	Left		
20/	20/		20/	20/
		Both		

	SE	DS	DC	Axis
Right				
Left				

Hyperopia +2.50 right eye: Pass Fail **Fusion:** Pass Fail

Hyperopia +2.50 left eye: 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"/>

***FOR CHILD WHO FAILED COLOR SCREENING: *Confirm Color Deficiency? Yes No**

Vision	Uncorrected		Corrected	
	Far	Near	Far	Near
Right				
Left				
Both				

Prescription given:

	Sphere	Cylinder	Axis	Add
Right				
Left				

PD: _____ / _____

Your treatment recommendations:

*Are glasses to be worn? Yes No

*When worn? (Check all that apply): Far For class and homework All the time
Near Gym/Sports

*New Prescription? Yes No

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

*Was child referred for additional vision care? Yes No

If yes, why? _____

Amblyopia therapy (if indicated)

*Is patch prescribed? School Home In which eye? Right Left Alternating

Alternative Therapy How many hours per day? _____

*Are blurring drops prescribed? School Home

School accommodations requested:

Special vision services recommended? Yes No If yes, see back page and describe _____

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

Protective lenses required? Yes No

*Doctor's Last Name: _____ *First Name: _____ *Specialty: _____

*Facility Name: _____

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

*Phone #: (____) _____ *License #: _____ *Email address: _____

PLEASE SEND ALL COMPLETED FORMS TO:

**School Health Vision Program
42-09 28th Street, Box 25
L.I.C., NY 11101-4132**

**If you have questions about the form, please call:
855-771-EYES (3937)**

**Please fax completed forms to:
347-396-8965**

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:

- Functional Vision Assessment
- Braille
- Large print reading materials
- Training with low vision devices
- Specialized adaptive computer technology
- Provide visual accommodations and support to student to access the curricula in all subject areas
- Instruction in orientation and mobility for independence in travel

For further information contact:

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

www.edvisionservices.org