*(PRINTED ON OFFICIAL SCHOOL LETTERHEAD)*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Parent/Guardian,

Your child recently participated in the vision screening program at our school. Your child tested (with glasses/contacts on) and ***did not*** pass the screening.

Perhaps you already have had your child examined by an ophthalmologist. If so, please send us a written note to that effect, and have the enclosed form completed by your eye specialist and returned to the school health office.

If your child has not seen an eye specialist recently, it is advisable to have an examination as soon as possible. When you go, please ask the eye specialist to complete the enclosed form and return it to us.

It is very important that we receive the completed enclosed form back from the eye specialist so we can incorporate their recommendations. This will ensure we are doing everything we can to help your child do their best at school.

If you have any questions, please contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

*(phone number)*

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, School Nurse  
 *(Printed Name) (Name of School)*

ENCLOSURE

*(PRINTED ON OFFICIAL SCHOOL LETTERHEAD)*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Physician,

As you know, school children are screened for vision problems as required by Massachusetts General Law. \_\_\_\_\_*(name of school)*\_\_\_\_\_ has implemented the Enhanced School Vision Guidelines developed by the Massachusetts Department of Health, released in September 2005, which include far vision (preschool-grade 12), near vision (grade 1-12), and stereopsis (preschool-grade 3).

Parents of children who did not pass the screening were asked to take the child to a vision specialist for evaluation. If the child is already under care, we need updated information for the child’s school health records.

In order that we may provide any educational adjustments you recommend, please complete the enclosed form below and ask the parent return the form to the school health office.

If you have any questions, please contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

*(phone number)*

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, School Nurse  
 *(Printed Name) (Name of School)*

Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This child did not pass the following component(s) of the vision screening:

|  |  |  |  |
| --- | --- | --- | --- |
| **Screening Performed** | **Tool used  for Screening** | **Screening Result** | **Other (glasses/contacts?)** |
| Linear Distance |  |  |  |
| Linear Near |  |  |  |
| Stereopsis/Ocular Alignment |  |  |  |
| Color (performed only as needed) |  |  |  |

Date of Examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brief summary of significant findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return visit recommended in \_\_\_\_\_ months.

I advise the following education adjustments for the child:

* None at present
* Preferential seating in classroom: Front: \_\_\_\_\_ Rear \_\_\_\_\_
* Glasses for full-time use in school
* Glasses for part-time use in school. Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_