*(PRINTED ON OFFICIAL SCHOOL LETTERHEAD)*

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

Dear Parent/Guardian,

Today I am sending you a second notice regarding a vision referral for your child. The first referral was sent out on \_\_\_\_\_*(date)*\_\_\_\_\_\_\_\_\_.

Poor vision can significantly impede your child’s ability to succeed in school.

The Massachusetts School Vision Screening Program has been one of the most successful initiatives implemented by the Massachusetts Department of Public Health over fifty years ago. Though school testing is a screening, not diagnostic, school district referral confirmation rates are quite high. In our ditrict last year, \_\_\_\_% of referrals sent and returned for vision confirm a vision disturbance. Comprehensive changes to school vision screening guidelines in Massachusetts include new screenings for stereopsis, which looks at how the two eyes work together, and near vision, in addition to far vision testing.

If you have already had your child’s vision checked, please contact me at \_\_\_\_*(phone number)*\_\_\_\_ and let me know the findings. If you have already forwarded me your referral completed by an eye specialist, let me know and I will try to rectify the situation. If your child has not yet seen an eye specialist since the original referral was sent, I encourage you to make an appoint to have your child’s vision checked. The referral form for the eye specialist is enclosed.

I thank you for your attention to this matter, and encourage you to call me with any questions..

Sincerely,

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

Cc: School Principal, \_\_\_\_\_*(insert name)*\_\_\_\_\_\_\_\_

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** | **ScreeningResult** | **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_