

STUDENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Center/Home Base: \_\_\_\_\_ Date: \_\_\_\_\_

Dear Parents/Guardians:

Your child failed two of the school's VISION \_\_\_ HEARING \_\_\_ screens. Failure to pass does not necessarily mean that your child has permanent vision/hearing loss. However it does indicate a need for further evaluation. Please follow up with your child's pediatrician or specialist and return the completed form below to your child's school nurse.

Sincerely,  
Health Services Staff

.....  
**VISION:** Dates Screened: \_\_\_\_\_ Screen Type: \_\_\_\_\_  
Screen Results: Acuity: Left: \_\_\_\_\_ Right: \_\_\_\_\_ Both: \_\_\_\_\_  
Glasses Worn/Prescribed: \_\_\_\_\_ Comments: \_\_\_\_\_

**DOCTOR'S/SPECIALIST'S RESULTS:**

- \_\_\_\_\_ Defect was found (Specify below.)
- \_\_\_\_\_ Defect was correctable.
- \_\_\_\_\_ No defect was found.
- \_\_\_\_\_ Referred to Specialist

ADDITIONAL COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Follow Up Appointment: \_\_\_\_\_  
.....

**HEARING:** Dates Screened: \_\_\_\_\_ Screen Type: \_\_\_\_\_  
Screen Results: Left: \_\_\_\_\_ Right: \_\_\_\_\_ Comments: \_\_\_\_\_

**DOCTOR'S/SPECIALIST'S RESULTS:**

- \_\_\_\_\_ Defect was found (Specify below.)
- \_\_\_\_\_ Defect was correctable.
- \_\_\_\_\_ No defect was found.
- \_\_\_\_\_ Referred to Specialist

ADDITIONAL COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Follow Up Appointment: \_\_\_\_\_