



STUDENT'S NAME: _____ DATE OF BIRTH: _____

Center: _____ Date: _____ Phone: _____

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

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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: _____

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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: _____