FAIRBANKS NORTH STAR BOROUGH
SCHOOL DISTRICT
520 Fifth Avenue Fairbanks, AK 99701-4756
(907) 452-2000
www.k12northstar.org

Vision Screening Referral

Identifying Information		
Child's Name:	Date of Birth:	Grade:
Parent/Guardian Name:		

Screening Information		
Date of screening:		**Date of Referral:**
Wearing glasses/contacts	Glasses are broken/lost	Does not wear glasses/ contacts
Distance Vision Acuity	***Right*** 20/ ***Left*** 20/	Screening tool: Sloan Eye Chart
Observations/other tests/comments		

Eye Care Specialist Report				
Diagnosis: ___ Normal ___ Myopia ___ Hyperopia ___ Astigmatism ___ Strabismus ___ Amblyopia				
Other:				
Acuity		***OD***	***OS***	Field limitation ___Y ___N
Distance	Without glasses	20/	20/	Widest diameter (in degrees) of remaining vision field:
	With correction	20/	20/	
Near	Without glasses	20/	20/	OD
	With correction	20/	20/	OS
RECOMMENDATION OF EXAMINER: ___ Ophthalmologist ___Optometrist				
Glasses prescribed ___ Yes ___ No Comments				
If yes, to be worn: ___ constantly ___classroom only ___distance only _____near only ___ sports glasses for PE/sports				
School Accommodations ___preferred seating ___extra lighting ___remove glasses for PE Physical activity limitations (specify)				
Comments				
Return visit recommendation:				
Signature of Examiner:				**Date:**

Parent authorization for release of information	
I the parent/guardian of the above named child, authorize the exchange of information between the eye care specialist and my child's school/school nurse. I understand this form will be faxed to the school nurse so she/he may assist in assuring the above recommendations can be followed to benefit my child's learning.	
Parent/Guardian Signature:	**Date:**
Return to school nurse	
To:	**From:**
School Nurse	Examiner
Address	Address
Phone	Phone
Email	Email
Fax	Fax