

D.C. EVEREST AREA SCHOOL DISTRICT  
CHILDREN'S VISION SCREENING REQUEST

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

Dear \_\_\_\_\_

\_\_\_\_\_ was screened for possible visual difficulty by the D.C. Everest School Nurse, in cooperation with Prevent Blindness-Wisconsin. Your child did NOT pass the screening.

WE RECOMMEND THAT YOU TAKE YOUR CHILD FOR A COMPLETE PROFESSIONAL EYE EXAMINATION by an ophthalmologist or optometrists for the reason checked below:

\_\_\_\_\_ your child was unable to see the line on the chart appropriate for age group  
(right eye \_\_\_\_\_ left eye \_\_\_\_\_)

\_\_\_\_\_ your child did not pass the depth perception check

\_\_\_\_\_ other: \_\_\_\_\_.

We want to make sure YOUR child has two good eyes. Please take this letter with you when you have your child's eyes examined. The form should be completed and returned to the address BELOW.

If your child was recently examined by an ophthalmologist or optometrist or is currently under treatment, please indicate below and return to us.

If you have questions about the screening, feel free to call the School Nurse at 359-4221, Ext. 320 or PREVENT BLINDNESS-WISCONSIN at (414) 765-0505.

\_\_\_\_\_  
School Nurse

DEAR DOCTOR:

In order to evaluate the effectiveness of this program, we ask you to complete and return this form to:

**District School Nurse**  
**D.C. Everest Area School District**  
**6300 Alderson Street**  
**Schofield, Wisconsin 54476**  
Confidential -for statistical purposes only

VISUAL ACUITY:

uncorrected

Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_

corrected

Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_

DIAGNOSIS:

Normal exam \_\_\_\_\_

Amblyopia \_\_\_\_\_

Muscle imbalance \_\_\_\_\_

Refractive error: myopia \_\_\_\_\_

HISTORY:

New case \_\_\_\_\_

Previously diagnosed \_\_\_\_\_

hyperopia \_\_\_\_\_ astigmatism \_\_\_\_\_

other \_\_\_\_\_

Treatment: glasses prescribed \_\_\_\_\_ other \_\_\_\_\_

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

Examiner's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

