CRANSTON PUBLIC SCHOOLS
VISION SCREENING REFERRAL

Name:_____ **Date:**_____
Grade:_____**Room:**_____ **School:**_____

Your child has recently failed vision screening on two separate occasions. We recommend that your child have an eye examination. Please have this form completed and returned to the school nurse. Thank you for your cooperation.

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Vision Acuity: W/O Lenses RE_____LE_____Refractive Error_____
W Lenses RE_____LE_____Muscles_____
Pathology_____
Recommendations_____

Are glasses required for school?_____Return Visit:_____

_____
Doctor's Signature Date

H-20B
Revised 11/99