GRACE LUTHERAN CHURCH AND SCHOOL

Discipled BY Grace FOR Grace

Vision Screen / Eye Examination

Please contact the school office if you have any questions about completing this application.

1007 Bacon Ranch Road, Killeen, Texas 76542 ♦ (254) 634-4424 ♦ www.gracelcs.com ♦ school@gracelcs.com

ATTENTION PARENTS : The Vision and Hearing Screening Program requires that every child have an eye examination or an approved vision screening test prior to or within 120 days after entry into a Texas licensed child-care facility or school.

Student Name ________________________ Date of Birth ____________________

Parent's Names ________________________ Phone ____________________

Address ____

(Street) *(City)* *(State)* *(Zip)*

The tests conducted to evaluate your child's vision are screens, they are not diagnostic. This means that if the child fails a screen, it is necessary for your child to be evaluated by a vision specialist, an ophthalmologist, or an optometrist to determine where there is a vision problem. It also means that on some occasions a vision problem may exist that the screens will not identify.

VISION SCREENER REPORT

DISTANCE ACUITY SCREEN

1st Screen Date __________	2nd Screen Date __________	Comments / Observations
With Correction ☐ Yes ☐ No	With Correction ☐ Yes ☐ No	
Chart Used	Chart Used	
Letter ☐ Right Eye 20/	Letter ☐ Right Eye 20/	
"E" ☐ Left Eye 20/	"E" ☐ Left Eye 20/	
H.O.T.V	H.O.T.V	
Machine ☐ Pass ☐ Fail	Machine ☐ Pass ☐ Fail	

HIRSCHBERT CORNEAL LIGHT REFLEX TEST	COVER AND UNCOVER	
☐ Light reflection is centered or slightly toward the nose the same distance in each eye.	Near: 12-13 Inches	Far: 10-20 Feet
☐ Light reflection is not centered Nor slightly toward the nose The same distance in each eye.	☐ No Eye Movement	☐ No Eye Movement
	☐ Eye Movement	☐ Eye Movement
☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail

Date of Final Screen ____________________ **Name of Screener** ______________________________

REFERRAL TO AN EYE CARE SPECIALIST (OPHTHALMOLOGIST OR OPTOMETRIST) DUE TO:

- ☐ Distance Acuity Test
- ☐ Hirschbert Corneal Light Reflex Test
- ☐ Cover and Uncover Test
- ☐ Parent / Doctor Request
- ☐ Observable Signs or Symptoms

  ____
  (describe)

- ☐ Other

  ____
  (describe)

- ☐ Unscreenable

WAIVER OF REFERRAL

My child ____ is being seen by an eye care specialist,

____ (doctor's name), for the problem(s) indicated above.

Parent Signature ____ Date __________________