School Vision Referral
Second Notice

Date: ____________

Dear Parent/Guardian,

Today I am sending you a second notice regarding a vision referral on your child _____________________. The first referral was sent ____________________. Poor vision can significantly impede your child’s ability to succeed in school.

The Massachusetts School Vision screening program has been one of the most successful initiatives implemented by the Department of Public Health over fifty years ago. Though school testing is “screening” and not diagnostic, school district referral confirmation rates are quite high. In our district last year, ____% of referrals sent and returned for vision confirm a vision disturbance. Comprehensive changes to school vision screening guidelines in Massachusetts include new screening for stereopsis testing which looks at how the two eyes work together and near vision screening, in addition to testing for far vision.

If you have already had your child’s vision checked, please give me a call at _______________ and let me know what the findings were. If you have already forwarded me the completed referral, let me know and I will try to rectify the situation. If your child has not seen an eye specialist since the original referral was sent, I encourage you to make an appointment and have your child’s vision checked.

I thank you for your attention to this matter and encourage you to call with any questions. Thank you for your attention to this matter.

Sincerely

__________________, School Nurse  Tel: ____________________

Cc: _____________________, Principal
School Vision Referral  
Second Notice

Dear Physician:  Date:  ________________

As you know, school children are screened for vision problems as required by Massachusetts General Law.  ______________ has implemented the Enhanced School Vision Guidelines developed by DPH and released in September 2005, which include far vision (preschool-grade 12, near vision (grade 1-12) and stereopsis for preschool through 3rd grade.

The child indicated below did not pass the following component(s) of the vision screening:

<table>
<thead>
<tr>
<th>Screening performed</th>
<th>Tool used for Screening</th>
<th>Screening Result</th>
<th>Other (glasses/contacts?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear Distance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear Near</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stereopsis/Ocular Alignment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Color (performed only ‘as needed’)</td>
<td></td>
<td></td>
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</tbody>
</table>

Parents of those children failing the screening are asked to take the child to a vision specialist for evaluation. If the child is already under care, we need updated information for the child’s school health records.

In order that we may provide any educational adjustments you recommend, please complete the form below and have the parent return the form to the school health office.

Sincerely,

_____________________, School Nurse
Tel.:  ______________________

Child’s name:  ________________________  Date of Examination:  ___________
School:  ______________________________  Grade:  _________

Brief summary of significant findings:  ______________________________________________
Diagnosis:  ___________________________  Treatment:  _______________________________
Prognosis:  ____________________________  Return Visit recommended in _______months.

I advise the following education adjustments for the child:

☐ None at present
☐ Preferential seating in classroom  Front_____ Rear_____
☐ Glasses for full-time use in school
☐ Glasses for part-time use in school.  Specify:  _______________________________
☐ Other recommendations_____________________________________

Signature:  _______________________________  Phys./Practice Name:  ____________________
Address:  _______________________________  Telephone:  _________________________