RIALTO UNIFIED SCHOOL DISTRICT
HEALTH SERVICES
815 S. Willow Avenue, Rialto, CA 92376 • Tel (909) 873-4302 • Fax (909) 873-4303

VISION REFERRAL

School: _____ **Date:** _____

Address: _____ **Teacher:** _____

Phone: _____ **Grade:** _____

Dear Parent:

A recent vision screening at school indicates your child _____ may have some vision difficulty. An eye examination is recommended as soon as possible. Your signature below will authorize your child's eye doctor to return the important information to the school nurse. Kindly take this form with you at the time of the examination. We thank you for your cooperation.

If you do not have insurance, we can offer assistance to you. Please fill out the attached financial form and return it to the Health Office at _____.

Parent Signature	Date	School Nurse

Dear Doctor:
The above named child was advised to seek an eye examination because our screening procedures indicate the possibility of visual difficulties.

Visual Acuity: Right: _____ Left: _____ ☐ with glasses ☐ without glasses

Comments: _____

Please return the information requested and your recommendation. This will be helpful to the school staff in arranging this pupil's educational program.

EYE EXAMINER'S REPORT TO THE SCHOOL

Visual Acuity

Without lenses: R.E. _____ L.E. _____ Both _____

With lenses: R.E. _____ L.E. _____ Both _____

Were glasses prescribed: ☐ Yes ☐ No Contact lenses: ☐ Yes ☐ No

Glasses should be worn constantly: _____

Preferential seating recommended: _____

Child should return for further care: _____

Other recommendations or suggestions: _____

Examiner's Name (*please sign or stamp*)	Date

Telephone	Address

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REFERENCIA DE VISIÓN

Escuela: _____ **Fecha:** _____

Dirección: _____ **Maestro (a):** _____

Teléfono: _____ **Grade:** _____

Dear Parent:

Recientemente se le hizo un examen de visión a su hijo(a) _____ en la escuela. Este examen indica que su hijo(a) tal vez tenga dificultades con su visión. Se le recomienda que se le haga un examen de los ojos tan pronto posible. Su firma abajo da autorización para que el doctor devuelva la información necesaria a la enfermera escolar. Por favor lleve esta forma al doctor el día del examen. Agradecemos su cooperación.

Si usted no tiene seguro le podemos asistir. Por favor llene la forma adherida y entréguela a la oficina de salud de _____.

Firma de Padre/Tutor Legal	Fecha	Enfermera Escolar

Dear Doctor:
The above named child was advised to seek an eye examination because our screening procedures indicate the possibility of visual difficulties.

Visual Acuity: Right: _____ Left: _____ ☐ with glasses ☐ without glasses

Comments: _____

Please return the information requested and your recommendation. This will be helpful to the school staff in arranging this pupil's educational program.

EYE EXAMINER'S REPORT TO THE SCHOOL

Visual Acuity

Without lenses: R.E. _____ L.E. _____ Both _____

With lenses: R.E. _____ L.E. _____ Both _____

Were glasses prescribed: ☐ Yes ☐ No Contact lenses: ☐ Yes ☐ No
Glasses should be worn constantly: _____
Preferential seating recommended: _____
Child should return for further care: _____
Other recommendations or suggestions: _____

Examiner's Name (*please sign or stamp*)	Date

Telephone	Address