San Francisco Unified School District
Student, Family, and Community Support Department
1515 Quintara St.
San Francisco, CA 94116
415/242.2615
Fax: 242.2618
http://www.healthiersf.org

Dear Parent/Guardian:

A vision screening was conducted at your child's school on _____________.
Your child did not pass the vision screening and must have his/her eyes examined.

- Please take your child to an eye doctor for further evaluation or treatment. Please have the eye doctor complete the back of this form and mail it to the above address.

- If you do not have an eye doctor, you may contact your own medical practitioner for a referral or go to an eye doctor (optometrist) near your home. Please make sure that the eye doctor accepts your child's insurance prior to making an appointment. If you do not have vision insurance, please review the attachments in this referral.

If you have questions regarding this referral, please do not hesitate to contact the screener directly: OPTOMETRIC EYECHECKERS, INC. at (415) 375-0393 or by email through their website http://eyecheckers.thruhere.net.

You may also contact the Nurse of the Day, **415-242-2615,** if you need further information about getting an eye exam for your child.
Thank you.

VISION SCREENING RESULTS

______________________	____________	___	________
Name of Student	*School*	*Gr*	*HO#*
______________________	______________________		
Street Address	*City/Zip Code*		

SNELLEN TEST: (R) 20/______ (L) 20/______ ☐ *Examined with glasses on*

☐ *Myopia* ☐ *Hyperopia* ☐ *Astigmatism* ☐ _____*tropia*

Other: ____

Dear Eye Care Practitioner:
This student is being referred to you because s/he did not pass her/his vision screening at school. Please examine the child, complete the report below and return it to:

School Health Programs, SFCSD, SFUSD
Attention: Vision Screening Program
1515 Quintara Street, San Francisco, CA 94116

DATE OF EXAM: ______/______/______

Refractive Condition:____

VISUAL ACUITY	**WITHOUT CORRECTIVE LENSES**	**WITH CORRECTIVE LENSES**	**NEAR ACUITY** ❑ WITH RX ❑ WITHOUT RX
O.D.			
O.S.			
O.U.			

Were glasses prescribed? ☐ Yes ☐ No

When should student wear glasses?
- ❒ All the time
- ❒ Classroom Only
- ❒ Other: ______________________

Were glasses ordered for student?
- ❒ No
- ❒ Yes, to be picked up on or around ____________________

Other conditions found: ____

Recommendations:
- ❑ Preferential Seating
- ❑ Referral to SFUSD Visually Impaired Services
- ❑ Other: ____

Name of Eye Examiner: ____

Signature: __________________________________**Date:** _________________

Address: ____________________________________**Phone:** _________________

Thank you very much for completing and returning this form.