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

親愛的家長/監護人：

在_____（日期）您子女在學校獲得了視力檢查。但他/她沒有通過今次檢查，而必須接受進一步評估。

- 請帶您子女到一位眼科醫生處作進一步評估及治療。請叫眼科醫生填寫此信的背面，並寄回上址。

- 如果您沒有自己的眼科醫生，請聯繫您的家庭醫生要求轉介，或親臨您家附近的眼科診所。在預約前，請確保眼科醫生接受您子女的保險。如果您沒有眼科保險，請參閱此轉介信的附頁資料。

如果您對本轉介信有疑問，請隨時直接聯絡驗眼機構 OPTOMETRIC EYECHECKERS, INC ，電話：（415）375-0393 ，或登上他們的網站（http://eyecheckers.thruhere.net）發電郵給他們。

若您需要知道更多有關如何帶子女驗眼的資訊，您也可以聯絡上學日健康計劃的護士，電話：415-242-2615。
多謝合作

視力檢查報告

_____ _____ ___ _____
學生姓名 *學校* *年級* *學號#*

_____ _____
學生住址 *市/郵編*

SNELLEN 測驗 (右眼) 20/_____ (左眼) 20/_____ ☐ 驗眼時戴著眼鏡

☐ *近視* ☐ *遠視* ☐ *散光* ☐ _____*斜視*

其他: _____

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.