DEPARTMENT OF HEALTH

Vision Referral Letter

Child's Name: _____ Date of Birth: _____

Dear Parent/Caregiver:

Our school provides vision screening using the guidelines developed Minnesota Department of Health. Your child's vision was screened on _____.

Please take your child to an eye doctor to check their vision. Give this letter with the school vision screen results to the eye doctor.

- ☐ Right Eye 10/_____ (20/_____) Left Eye 10/_____ (20/_____) for distant vision.
- ☐ Your child was unable to read lines on the chart for their age OR the difference between vision in the left and right eye was greater than one line (with) (without) corrective lenses.
- ☐ Your child had trouble seeing objects close-up (Plus lens screening).
- ☐ Your child complained that it is hard to see well.
- ☐ The appearance of your child's eye/s was not typical for most children. Explanation: _____
- ☐ Possible eye muscle balance problems (pupils looking the same direction) was observed during screening
- ☐ Abnormal Retinal (Red Light) Reflex
- ☐ Child/Family history of eye conditions.

If you have questions or need help getting an exam by an eye care professional, please contact us.

_____

Please have your eye care professional complete the form and return the completed form to your school.

Health Care Provider, please complete this form.

Child's Name: _____ Date of Birth: _____

School Name: _____

Provider comments:

I have examined this child on_____/_____/_____

My findings are:

Right: 10/_____ (20/_____) Left: 10/_____ (20/_____) without corrective lenses

- ☐ Insufficient to require treatment
- ☐ Corrective lenses prescribed or there is change in the current prescription.
- ☐ Best Correction: R_____/_____ L_____/_____
- ☐ Muscular Condition was not found or insufficient to require treatment
- ☐ Muscular Condition is being treated by corrective lenses or other method
- ☐ There is no significant visual condition that will impact the child's learning
- ☐ This child has a visual condition that may impact learning. Recommendations include:
- ☐ _____
- ☐ Other _____

Child should return for follow up examination on _____

Provider Name/Title: _____

Contact Information: _____

Schools nurse or health staff fill out this section below before sending home

Please have the parent return this form to the school or you can return this to

School Nurse Name: _____

Phone: _____

Address: _____

_____

Email: _____

This templated form was developed by MDH for use in schools.

Minnesota Department of Health
Child and Teen Checkups
651-201-3650
health.childteencheckups@state.mn.us
www.health.state.mn.us

11/2023

To obtain this templated in a different format, call: 651-201-3650.