

# HEAD START VISION SCREENING AND EXAMINATION FORM

Return Form To:

Child's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

**GARRETT HEAD START**

Parent's Name \_\_\_\_\_

504 South Second St.

Home Address \_\_\_\_\_

Garrett, IN 46738

Telephone \_\_\_\_\_

(260) 357-3333

FAX (260) 357-3044

**VISUAL ACUITY:**

Distance      right eye 20/ \_\_\_\_\_      left eye 20/ \_\_\_\_\_      both eyes 20/ \_\_\_\_\_

Near            right eye 20/ \_\_\_\_\_      left eye 20/ \_\_\_\_\_      both eyes 20/ \_\_\_\_\_

Evaluation	<u>Pass</u>	<u>Needs Further Evaluation</u>
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RETINOSCOPY (prescription estimation)	_____	_____
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OPHTHALMOSCOPY (eye health)	_____	_____
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COLOR PERCEPTION	_____	_____
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DEPTH PERCEPTION	_____	_____
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EYE COORDINATION		
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Distance	_____	_____
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Near	_____	_____
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VISUAL PERCEPTION	_____	_____
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(form perception)		
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\_\_\_\_\_ No additional treatment needed at this time.

\_\_\_\_\_ Additional treatment needed, Explain: \_\_\_\_\_

\_\_\_\_\_ Glasses prescribed

I, \_\_\_\_\_, parent/guardian of above minor child authorize provider listed below to release this form to GKB Head Start via mail, fax or in person.

(Parent/Guardian Signature)

(Date)

\_\_\_\_\_  
Vision Care Provider Printed Name

\_\_\_\_\_  
Vision Care Provider Signature

\_\_\_\_\_  
Examination Date