Arkansas Department of Education

Vision Screening Program

Name of District/Private School _____ County _____

Vision Screening Summary Form

Number of Students	Pre-K	Kindergarten	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	Transfer	District Total
Screened																
Rescreened																
Referred																
Received Examination																
Confirmed Difficulty by Professional																
Confirmed Normal Eye/Vision by professional																

Form completed by: **Name of Screener(s)** **Title**

_____ _____

_____ _____

Mailing Address: _____ _____

E-mail Address: _____ _____

_____ _____

Form VHSP-6(10-02)

Revised June 2006

INSTRUCTIONS: Please mail the completed form to the ADE Vision Screening Program, 2020 W. 3rd Street, Suite 320, Little Rock, AR 72201, Attn: Paula Smith