NOTICE TO PARENTS OF NEED FOR AN EYE AND VISION EXAMINATION

Date: ___________________________ School: ___________________________
Student: ___________________________ Grade: ________ Teacher: ___________________________

Your child passed the eye and vision screening test: □ Yes □ No

REASON FOR NOT PASSING

Blurred vision at distance □   Eye Muscle Problem □
Blurred vision at near □   Eye Health □
Plus (+) Lens Test □   Other__________

Dear Parent:

Your child’s performance in school is dependent on his/her ability to see. Eighty (80%) of what we learn comes through our eyes. If your child’s eyes need help, please don’t deprive him/her of the opportunity to do as well as other children.

State law states: A child who does not pass the eye and vision screening tests shall be required to have a comprehensive eye and vision examination conducted by an optometrist or ophthalmologist within sixty (60) days of receipt of the vision screening report. Arkansas Code Annotated § 6-18-1502

Thank you for your cooperation.

Parent authorization to release medical eye information (Signature)________________________

REPORT OF DOCTOR’S EVALUATION

<table>
<thead>
<tr>
<th>Visual Acuity</th>
<th>@ 20 feet Without Rx</th>
<th>@ near Without Rx</th>
<th>@20 feet With Rx</th>
<th>@ near With Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>20/____</td>
<td>20/____</td>
<td>20/____</td>
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</tr>
<tr>
<td>Left</td>
<td>20/____</td>
<td>20/____</td>
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</tbody>
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Eye Muscles
A - Normal
B - Subnormal
Accommodation:______ Convergence:______ Binocularity:______ Eye movement:______

Eye/Vision Diagnosis
Right    Hyperopia____ Myopia____ Astigmatism____ Amblyopia____ Muscle Problem____
Left     Hyperopia____ Myopia____ Astigmatism____ Amblyopia____ Muscle Problem____

Internal and External Eye Health
Glasses Prescribed Yes □ No □ To be worn: Full time Distance only Reading only
Other problems (comments or instructions)________________________________________________________

Date of Examination: _______ / _______ / _______ Date of Re-examination: _______ / _______ / _______

Examiner’s Name_________________________ Signature_________________________

Address________________________________ Phone_________________________ Date: ___________________________

________________________________________________________

Please fax to: ___________________________ Fax Number: ___________________________

Revised June 2006