ROSLYN PUBLIC SCHOOLS

DEPARTMENT OF HEALTH, PHYSICAL EDUCATION AND RECREATION

HEALTH SERVICES

PARENT NOTIFICATION REGARDING VISION

Date: ____________________

____
Student's Name **Date of Birth**

____
Address **Grade**

____

To Parent or Guardian:
A recent evaluation indicates that your child may have some eye difficulty. A complete eye examination is required to determine the need for professional care. This completed form should be returned to the school nurse.

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To the Examiner:
This student needs clearance for contact sports due to uncorrected vision of 20/40 or less: left eye/right eye

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Your diagnosis and commendation will help in planning for this child's school program.

____

Report of Eye Specialist:
1. Diagnosis: Right eye: ____________________ Left eye: ____________________

2. Visual acuity (a) Without R ________________ (b) With R ________________

Correction L ________________ (b) Correction L ________________

3. Can this student participate in interscholastic contact sports? YES NO

Examiner's Address: ____

Phone Number: ______________________________ **Date of Examination:** ____________

When should this pupil be re-examined? ______________________________________

Examiner's Signature & Title: ______________________________ **Date:** ____________