Lowndes County
Board of Education Head Start

Vision Exam Follow Up HEA-249

Attending Doctor:

This child's vision was recently screened at school, and a professional eye examination was recommended based on the results of the screening. Please complete the report form and fax it to Lowndes County Board of Education Head Start at 334-548-2021.

Child's Name:_____

Date of Birth: _____/_____/_____ **Date of Examination:**_____

Visual Acuity:

Distance: Right 20/_____ Left 20/_____
Near: Binocular: 20/_____

Diagnosis:

☐ Amblyopia

☐ Muscle Imbalance
(Specify)_____

☐ Refractive Error: ☐ Myopia ☐ Hyperopia ☐ Astigmatism

☐ Other (Specify)_____

☐ No Problem Detected

Treatment:

☐ Glasses Prescribed: ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time (Specify)_____

☐ Other (Specify)
_____

☐ Follow-Up Care Recommended_____

Examiner's Name_____ **Signature**_____

Address_____

Phone Number_____

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Consent of Parent/Guardian: I agree that the above information may be released to the school system for the purpose of providing educational services to my child.

Date_____ ***Parent/Guardian Signature*** _____

R—3/15