BREMEN PUBLIC SCHOOLS
PRE-SCHOOL VISION SCREENING REPORT

Child's Name: _____Date: _____

Address: _____Age: _____

Parent/Guardian: _____

Before starting school the visual status of your child's eyes should be known. Therefore, it is recommended that a check for visual defects (problems) be done by your eye examiner to determine if a more comprehensive analysis is necessary.

Visual Acuity: Near- Right Eye 20/ Left Eye 20/
Distance- Right Eye 20/ Left Eye 20/
Screened with/without glasses? (Please circle one)

Eye coordination:

	Underconvergence	Normal	Overconvergence
Distance	_____	_____	_____
Near	_____	_____	_____

Fixation & Version Ability: Adequate: _____ Inadequate: _____

Refractive State:

	Right Eye	Left Eye
Normal	_____	_____
Farsighted	_____	_____
Nearsighted	_____	_____
Astigmatism	_____	_____

Eye Health:
External_____
Internal_____

Comments:
_____
_____

This visual screening indicates:
1. Visual readiness within normal limits at this time. _____
2. Complete eye examination necessary as soon as possible. _____
3. Visual analysis recommended in one year. _____

_____
Signature of Examing Eye Doctor