Iowa Department of Public Health

CERTIFICATE OF VISION SCREENING

Pursuant with Iowa Code Chapter 641.52

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information vision testing requirements can be accomplished either through a screening (see below) or with a comprehensive eye exam (see other side). Screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*

Date of Vision Screening: _____

Result: (Please check): ☐ Pass or ☐ Fail

Testing method: (Please check) ☐ Vision Screening ☐ Photo Screen ☐ Other**:** _____

Visual Acuity: (if available) ☐ With Correction ☐ Without Correction

Right Eye_____Left Eye_____

Referral to eye health professional: (Please check) ☐ Yes or ☐ No

Business Name/Source of Screening: (please print name of provider office or if provided by school nurse, name of school)

_____

Provider Name: (please print) _____Phone: _____

Signature and Credentials of Provider: _____Date: _____

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten **and** again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and 3rd grade and no later than six months after the date of the child's enrollment in Kindergarten and 3rd grade.

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Iowa Department of Public Health • Bureau of Family Health
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Eye Exam Section

Pursuant with Iowa Code Chapter 280.7A

To the Parent or Guardian: The Iowa Optometric Association strongly recommends that to fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. **If you choose to** take your child to an eye care professional for a comprehensive eye exam, this side of the form should be filled out and signed by the eye care professional and returned to the school nurse or teacher by your child.

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health

☐ Normal ☐ Other

Internal Eye Health

☐ Normal ☐ Other

Vision Analysis

R	**L**		
☐	☐	Normal eyesight	☐ Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐ Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐ Eye focusing difficulty
☐	☐	Astigmatism	☐ Sensitivity to light
☐	☐	Amblyopia	

☐ Other_____

Vision Correction Recommendations

☐ No correction necessary

☐ No change in present prescription

☐ New prescription needed

To be worn for:

☐ Constant wear ☐ Near vision only

☐ Distance vision only ☐ As needed

To the Eye Care Professional: Please sign and date this form after the examination.

Dr. Name (Please Print) _____

Date_____ Signature_____