BETHEL PUBLIC SCHOOLS

Name _____ School _____ Date _____

Results of eye screening by the school nurse indicates that your child should be seen by an eye doctor.

_____

_____

If you do not know of an eye doctor, we suggest that you ask your family physician to recommend one. If you have questions, please call me. I can be reached at _____ .

_____
School District Nurse

(Please take this form to the doctor.)

Name _____ Date _____

Glasses: None needed ☐ New Prescription ☐

To be worn _____

Best correction to be expected by glasses: R _____ L _____

Visual acuity without glasses: R _____ L _____

Eyes should be rechecked by doctor on this date: _____

Other remarks: _____

_____

_____

_____

_____ _____
Date Doctor's Signature

PARENTS NOTE: Please return this report to the school so that it can be made a permanent part of your child's school health record for guidance of the Health Department and the classroom teachers. Thank you.