Health Office
Our Lady of Mercy Academy
815 Convent Road
Syosset, NY 11791
516-921-1047

SYOSSET HIGH SCHOOL

Health Office

364-5696

NOTICE REGARDING ANNUAL VISION SCREENING

Date____________________________

Student's Name _______________________________________ **Date of Birth** __________________

Grade_________

VISION SCREENING: R______________ **L**____________

To the Parent/Guardian:

The results of the annual vision screening suggest that your child's eyes need to be checked. We recommend that the child have a complete eye examination.

Please ask the examiner to complete this form.
We ask that you return the completed form to the school's Health Office.

EXAMINER'S DIAGNOSIS AND RECOMMENDATIONS

Diagnosis: ____

Visual Acuity:

(A) Without Correction:

R__________

L__________

(B) With Correction:

R__________

L__________

Are Glasses to be worn: Yes_______ No_______

Have Contact Lenses been recommended: Yes_______ No_______

Are there any activities that should be limited because of this condition? Yes_______ No_______

If Yes, please specify:____

____

____

Do you recommend that this child wear glasses while participating in physical activities *(physical education classes, free play, sports, etc.)* ____

____

Do you wish to see this child again? Yes______ No______ If yes, when?______________________

____
Date of Exam

____
Signature of Examiner

____
Print Name of Examiner

____
Print Address of Examiner