



### Certificate of Record for Vision Screen and/or Eye Examination

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

#### DISTANCE ACUITY SCREEN

**1st Screen (Date):** \_\_\_\_\_

With Correction:  Yes  No

**Chart Used:**  Sloan Letter  HOTV

**Result:** (R) Eye **20/** (L) Eye **20/**

**2nd Screen (Date):** \_\_\_\_\_

With Correction:  Yes  No

**Chart Used:**  Sloan Letter  HOTV

**Result:** (R) Eye **20/** (L) Eye **20/**

**Comments/Observations:**

#### AUTOMATED SCREENING DEVICE

**Type of Device:**  Photo Screener  Auto-Refractor  Other

**Result:**  PASS  FAIL

#### HIRSCHBERG CORNEAL LIGHT REFLEX TEST

Light reflection is centered or slightly toward the nose the same distance in each eye.

Light reflection is not centered nor slightly toward the nose the same distance in each eye.

**Result:**  PASS  FAIL

#### COVER AND UNCOVER TEST

**NEAR: 12 to 13 inches**  No Eye Movement  Eye Movement

**FAR: 10 to 20 feet**  No Eye Movement  Eye Movement

**Result:** **Near:**  PASS  FAIL **Far:**  PASS  FAIL

#### REFERRAL REASON (If applicable)

Distance Acuity Screen

Parent/Doctor Request

Automated Screening Device

Unable to Screen

Hirschberg Corneal Light Reflex Test

Other:

Cover and Uncover Test

**Observable Signs or Symptoms (describe):**

#### SCREENING CERTIFICATION

Signature of Screener:

Date:

Print Name of Screener:

**ATTENTION PARENT:** The Vision and Hearing Screening Program requires that every child have an eye examination or an approved vision screening test prior to or within 120 days after entry into a Texas public or private preschool or school, licensed child care center, or child care home.

The tests conducted to evaluate your child's vision are screens; they are not diagnostic. This means that if your child fails a screen, it is necessary for him or her to be evaluated by his or her primary care provider to determine whether there is a vision problem. It also means that on some occasions a vision problem may exist that the screens will not identify.

**\*\*\* WAIVER OF REFERRAL \*\*\***

My child \_\_\_\_\_ (name of child) is being seen by an eye care specialist, \_\_\_\_\_ (doctor's name), for the problem(s) indicated.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**If "Waiver of Referral" is complete, it should be returned to the school.**