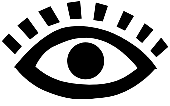

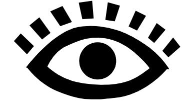

WOOD COUNTY HEAD START, INC.

VISION REFERRAL

1011 8TH STREET SOUTH
WISCONSIN RAPIDS, WI 54494
715-421-2066 ~ FAX 715-421-2069

Dear Parent:

When your child began preschool, you completed a vision screening consent form. We screen the children using a portable SureSight Vision Screener. If the child does not pass the first screen, we will complete a second screening if necessary.

Recently your child completed those screenings and did not pass. We recommend you make an appointment with an eye doctor of your choice as soon as possible. When you visit the eye doctor please give this form to him/her. We are requesting the doctor fill the form out and send it back to the address above.

Child's Name: ____ Birth Date: ________

Parent/Guardian: ____

Wood County Head Start, Inc. Initial screening Date: ____________________

Results: L ______ R______ Both L & R _______

Rescreen: Date: __________ Results:__________________
____

Dear Doctor,

The above named child has participated in the Wood County Head Start vision screening procedure and did not pass. After examination, please fill in the following information and any treatment or comments that would help us better serve the child's needs while enrolled in our program. Please send or fax this form to the above address when completed. This information will be kept in the child's file.

Eyes and visual performance satisfactory ____________
I recommend further visual study on (date) ____________
In need of visual training ____________
In need of eye surgery or medication ____________
Referred to family physician ____________
Visual acuity w/glasses within normal limits ____________
Glasses have been prescribed for:
distance_____ near_____ constant____

Comments:____
____

Name of Clinic:____

Doctor's Signature:_______________________________________ **Date:**_____________