OUR LADY of MOUNT CARMEL
CATHOLIC SCHOOL

STUDENT VISION SCREENING FORM

NEEDS TO BE PERFORMED BY AN OPTOMERTRIST OR AN OPTHALMOLOGIST
TO SATISY THE STATE HEALTH MANDATE
REQUIREMENT FOR KINDERGARTEN ADMISSION TO OLMC

NAME_____ DATE_____

OBSERVATIONS OR COMPLAINTS RELATIVE TO VISION_____

_____

SCREENED WITH GLASSES YES_____ NO_____

1. **VISION DISTANCE R_____ L_____ VISION NEAR R_____ L_____**
2. **COVER TEST PASS_____ FAIL_____**
3. **STEREOPSIS PASS_____ FAIL_____**
4. **RETINOSCOPY PASS_____ FAIL_____**
5. **OCULAR HEALTH EXTERNAL PASS_____ FAIL_____**

   INTERNAL PASS_____ FAIL_____

COLOR DEFINCIENCY NO_____ YES_____ TYPE_____

ADDITIONAL REMARKS:_____

_____

RESULTS OF VISION TEST: (CIRCLE ONE) PASS BORDERLINE FAIL

RECOMMENDATIONS/TREATMNET_____

_____

DOCTOR'S NAME: (PRINT) _____PHONE NUMBER_____

DOCTOR'S SIGNATURE_____

THIS FORM NEEDS TO BE RETURNED BY AUGUST 10, 2020

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