Return the completed form to the NYC DOHMH School Health Vision Program, 42-09 28th Street, Box 25, L.I.C. NY 11101-4132

NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE — NYC DEPARTMENT OF EDUCATION

EYE REPORT AND RECOMMENDATIONS

(Please print on hard surface)

*OSIS # _____ – _____ – _____

CHILD'S LAST NAME	CHILD'S FIRST NAME	SEX ☐ Male ☐ Female	DATE OF BIRTH

DISTRICT	BOROUGH	SCHOOL	GRADE/CLASS

*Date of issue: _____ *Issued by: _____ *Title: _____

*Reason for issue: _____

TO THE PARENT: Your child did not pass one or more parts of the vision screening. Please take your child to an eye doctor for an examination.

SCREENING RESULTS

Note: 20/40 or higher fails

Date of screening: _____ Team code: _____

FAR VISION Pass ☐ Fail ☐			NEAR VISION Pass ☐ Fail ☐	
Without	With glasses		Without	With glasses
20/	20/	Right		
20/	20/	Left		
20/	20/	Both	20/	20/

Reason for Pre-K Referral

☐ Refractive ☐ Alignment ☐ Pupils

	SE	DS	DC	Axis
Right				
Left				

Hyperopia +2.50 right eye: Pass ☐ Fail ☐ **Fusion:** Pass ☐ Fail ☐

Hyperopia +2.50 left eye: Pass ☐ Fail ☐ **Color test:** Pass ☐ Fail ☐

*TO THE EYE DOCTOR: Please fill out all fields, especially the fields marked with a red asterisk.**

EYE DOCTOR'S EXAMINATION

*Date of examination: _____ *Next Visit: (in months) _____

*Diagnosis:	Right Eye	Left Eye	Both Eyes
1) _____	☐	☐	☐
2) _____	☐	☐	☐
3) _____	☐	☐	☐
4) _____	☐	☐	☐

***FOR CHILD WHO FAILED COLOR SCREENING: *Confirm Color Deficiency? Yes ☐ No ☐**

Vision

	Uncorrected		Corrected	
	Far	Near	Far	Near
Right				
Left				
Both				

Prescription given:

	Sphere	Cylinder	Axis	Add
Right				
Left				

Your treatment recommendations:

*Are glasses to be worn? Yes ☐ No ☐

*When worn? *(Check all that apply):* Far ☐ Near ☐ For class and homework ☐ Gym/Sports ☐ All the time ☐

*New Prescription? Yes ☐ No ☐

*Does/will the child wear contact lenses? Yes ☐ No ☐

*Was child referred for additional vision care? Yes ☐ No ☐

If yes, why? _____

Amblyopia therapy (if indicated)

*Is patch prescribed? School ☐ Home ☐ Alternative Therapy ☐

In which eye? Right ☐ Left ☐ Alternating ☐

How many hours per day? _____

*Are blurring drops prescribed? School ☐ Home ☐

School accommodations requested:

Special vision services recommended? Yes ☐ No ☐ If yes, describe _____

Seating accommodation requested: Yes ☐ Any front seat ☐

Blackboard: Front Left ☐ Front Center ☐ Front Right ☐

Exclude from contact sports? Yes ☐ No ☐ If yes, until _____

Protective lenses required? Yes ☐ No ☐

*Doctor's Last Name: _____ *First Name: _____ *Specialty: _____

*Facility Name: _____

*Address: _____ City: _____ State: _____ Zip: _____

*Phone #: (___) _____ *License #: _____ *Email address: _____

For additional information, please call: 855-771-EYES (3937) or 718-310-2875 (English/Español)

COPIES: White (Vision Program); Canary (Medical Room); Pink (Parent)

PLEASE SEND ALL COMPLETED FORMS TO:

School Health Vision Program
42-09 28th Street, Box 25
L.I.C., NY 11101-4132

If you have questions about the form, please call:
855-771-EYES (3937)

Please fax completed forms to:
347-396-8965

If your child has very low vision, he or she may be eligible for special services provided by the New York City Department of Education.

Educational Vision Services

The New York City Public Schools provide specialized educational services for students who are blind or visually impaired. Students are eligible if their best-corrected vision in the better eye is 20/70 or lower, or if they have specified visual impairments, such as macular degeneration, retinopathy of prematurity, optic atrophy, high myopia or albinism. Services are designed to give students access to the general curriculum, and to participate in general or special education classes at the highest possible level of independence. Available services include:

- Braille
- Large print reading materials
- Training with low vision devices
- Specialized adaptive computer technology
- Instruction in other skills to attain literacy in:
  - reading
  - writing
  - mathematics
  - sciences
  - computers
- Instruction in orientation and mobility for independence in travel
- Bus transportation, if needed.

For further information contact:

Educational Vision Services
400 First Avenue, 7th Floor
New York, NY 10010