Form: F

Ohio Department of Health

Preschool Students Vision Screening Record

1st Screen Date	2nd Screen Date	School or Program
Grade	Teacher	

Student's Name	Observation	With Glasses	Without Glasses	Distance Visual Acuity*				Stereopsis		Near Acuity		Other		Referral
				1st		2nd								
				R	L	R	L	1st	2nd	1st	2nd	_____		

Other=Suresight and Retinomax. Indicate on line provided.
*= LEA Symbols and EYE Check at 5 feet indicate Pass (P) or Non Pass (NP)
HEA #0138