Form: H School Age Vision Screening Record

Ohio Department of Health

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*				Color Vision		Stereopsis		Near Visual Acuity		Referral
				1st		2nd								
				R	L	R	L	1st	2nd	1st	2nd	1st	2nd	

*= LEA Symbols at 5 feet indicate Pass (P) or Non Pass (NP)