LOVE SERVICE

Cleary School for the Deaf

301 Smithtown Boulevard, Nesconset, New York 11767-2077 631-588-0530
www.clearyschool.org

VISION SCREENING FORM

(required for students entering Pre-K or K, 1st, 3rd, 5th, 7th, and 11th grades, as well as all new entrants)

Student Name: _____ DOB: _____

Report of Eye Specialist:

Diagnosis: Right eye _____ Left eye _____ Both_____

Additional Medical Diagnosis: _____

Healthy eyes: Yes _____ No _____

Visual Acuity:

	Uncorrected		Corrected	
	Near	**Far**	**Near**	**Far**
Right (OD)				
Left (OS)				
Both (OU)				

***Peripheral Vision: _____**

Does the student require glasses? ❒yes ❒no *New Prescription? ❒yes ❒no
Prescription given: _____
Under what conditions should glasses be worn? (Check all that apply): ❒ near ❒ distance ❒full-time

School accommodations requested:
Special vision services recommended? ❒ yes ❒ no If yes, describe: _____

Seating accommodation requested: ❒ yes ❒ no

❒ Any front seat ❒ Blackboard: ❒ Front Left ❒ Front Center ❒ Front Right

Should physical activities be limited because of eye condition ❒ yes ❒ no

If yes, explain _____

Examiner's Name/Title and Signature _____
Facility Name and Address: _____
Phone Number: _____ Date of Exam: _____

Please Return to: Cleary's Main Health Office, 301 Smithtown Blvd., Nesconset, NY 11767
Roseann Nitz, RN, rnitz@clearyschool.org, Phone: 631-588-0530 ext. 218, Fax: 1-737-210-4796.