Issaquah School District #411
Conservation of Vision Program

Name: ______________________ **Grade:** ________ **Teacher:** ______________

School: ______________________________

Results of the eye screening by the school nurse indicates that your child should be seen by an eye specialist for further examination.

Vision: R ____________________ L ________________________

Observed symptoms: ____

Further comments: ____

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Call # __________________________ regarding any questions.

Signature: ____
Title Date

Please take this form to the doctor
Doctor's Report to School

Glasses: None needed ______________
To be worn ______________
Other ______________

Best correction to be expected by glasses: R __________ L __________

Suggestion as to specific needs for child's school program (special equipment, etc.)

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______________ ______________________________
Date Doctor's Signature

Note to Parent/Physician: Please return this report to the school.