Los Lunas Schools
Vision Screen

Vision Screening

Student: _____DOB: _____School: _____

Date of Referral: _____ Teacher: _____ Person Referring: _____

Wears Glasses: ☐ Yes ☐ No Wears Contact Lenses: ☐ Yes ☐ No

Screened: ☐ With Glasses ☐ Without Glasses

Far Vision: Left: _____ / _____ Right: _____ / _____ Test: _____

Near Vision: Left: _____ / _____ Right: _____ / _____ Test: _____

Stereopsis: ☐ Yes ☐ No Comments: _____ Test: _____

Ocular Alignment: ☐ Pass ☐ Fail Comments: _____ Test: _____

Color: ☐ Pass ☐ Fail Comments: _____ Test: _____

Ocular Function: ☐ Pass ☐ Fail Comments: _____ Test: _____
(tracking/convergence)

Ocular Health: ☐ Pass ☐ Fail Comments: _____ Test: _____

Results of this Evaluation: _____ _____ Date Parent/Guardian Notified (if failed): _____
Pass Fail

**Is the student able to undergo testing at desk range: ☐ Yes ☐ No

_____ _____ _____
Evaluator's Signature Position Date

DO NOT SCREEN IF: Student wears glasses and does not have them for testing.

DO NOT SUBMIT FOR EVALUATION UNTIL STUDENT PASSES SCREENING, FURTHER MEDICAL INFORMATION IS DOCUMENTED or RN INDICATES THAT STUDENT CAN BE TESTED AT DESK RANGE.