

**DEPARTMENT OF STATE HEALTH SERVICES
CERTIFICATE OF RECORD FOR
VISION SCREEN AND/OR EYE EXAMINATION**

ATTENTION PARENT: The Vision and Hearing Screening Program requires that every child have an eye examination or an approved vision screening test prior to or within 120 days after entry into a Texas licensed child-care facility or school.

SCHOOL NAME _____ CITY _____ COUNTY _____
 CHILD'S NAME _____ BIRTHDATE _____ AGE _____
 PARENT'S NAME _____ TELEPHONE _____
 ADDRESS _____ CITY _____ ZIP _____

The tests conducted to evaluate your child's vision are screens; they are not diagnostic. This means that if the child fails a screen, it is necessary for your child to be evaluated by a vision specialist, an ophthalmologist or an optometrist, to determine whether there is a vision problem. It also means that on some occasions a vision problem may exist that the screens will not identify.

**** VISION SCREENER REPORT ****

DISTANCE ACUITY SCREEN:

1 ST SCREEN: DATE _____ With Correction: <input type="checkbox"/> Yes <input type="checkbox"/> No Chart Used: Letter <input type="checkbox"/> Right Eye 20/ "E" <input type="checkbox"/> Left Eye 20/ H:O:T:V Machine <input type="checkbox"/> PASS <input type="checkbox"/> FAIL	2 ND SCREEN: DATE _____ With Correction: <input type="checkbox"/> Yes <input type="checkbox"/> No Chart Used: Letter <input type="checkbox"/> Right Eye 20/ "E" <input type="checkbox"/> Left Eye 20/ H:O:T:V Machine <input type="checkbox"/> PASS <input type="checkbox"/> FAIL	<u>COMMENTS/OBSERVATIONS:</u>
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HIRSCHBERT CORNEAL
LIGHT REFLEX TEST

COVER AND UNCOVER

<input type="checkbox"/> Light reflection is centered or slightly toward the nose the same distance in each eye. <input type="checkbox"/> Light reflection is not centered nor slightly toward the nose the same distance in each eye <input type="checkbox"/> PASS <input type="checkbox"/> FAIL	NEAR: 12-13 inches <input type="checkbox"/> No Eye Movement <input type="checkbox"/> Eye Movement <input type="checkbox"/> PASS <input type="checkbox"/> FAIL	FAR: 10 – 20 Feet <input type="checkbox"/> No Eye Movement <input type="checkbox"/> Eye Movement <input type="checkbox"/> PASS <input type="checkbox"/> FAIL
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REFERRAL TO AN EYE CARE SPECIALIST (OPHTHALMOLOGIST OR OPTOMETRIST) DUE TO:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Distance Acuity Test | <input type="checkbox"/> Observable Signs or Symptoms | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Hirschberg Corneal Light Reflex Test | _____ (describe) | _____ |
| <input type="checkbox"/> Cover and Uncover Test | <input type="checkbox"/> Parent/Doctor Request | <input type="checkbox"/> UNSCREENABLE |

DATE OF FINAL SCREEN: _____ **NAME OF SCREENER:** _____

***** WAIVER OF REFERRAL *****

My child _____ is being seen by an eye care specialist,
 _____ (doctor's name), for the problem(s) indicated.

Parent's Signature _____

Date _____