ST. JOSEPH SCHOOL
301 West Houston Street
Garrett, IN 46738
260-357-5137 FAX 357-5138
call@stjosephgarrett.org

Kindergarten Vision Screening

Child's Name_____ Age_____ Grade_____
Parent's Name_____ Date of Examination_____

Doctor's Report

Visual Acuity without glasses:

Distance	OD 20/_____	OS 20/_____	OU 20/_____
Near	OD 20/_____	OS 20/_____	OU 20/_____

Internal & External Screening(Eye Health Screening)		_____	_____
Retinoscopy (Estimation of Prescription)		_____	_____
Depth Perception		_____	_____
Color Perception		_____	_____
Visual Perception (Ability to move eyes together in all directions	----Distance	_____	_____
	----Near	_____	_____

Referral: Recommended_____ Not Recommended_____

Glasses were: Prescribed_____ Not Prescribed_____

If applicable, glasses should be worn: Constantly_____ Classroom_____ Desk Work_____
Reading_____ Distance_____
Can be removed for P.E./Recess_____

Visual Therapy was: Recommended_____ Not Recommended_____

Should return for further care_____
Other recommendations and observations_____
_____

Physician's Signature_____
Address_____
City, State, Zip_____

Parents: Please return this form to school office on or before first day of school.