Iowa Department of Public Health

CERTIFICATE OF VISION SCREENING
Pursuant with Iowa Code Chapter 641.52
RETURN COMPLETED FORM TO CHILD’S SCHOOL.

**Student Information** (please print)

<table>
<thead>
<tr>
<th>Student Last Name:</th>
<th>Student First Name:</th>
<th>Birth Date (M/D/YYYY):</th>
</tr>
</thead>
</table>

Parent/Guardian Telephone Number:  
Student Address:  
Zip Code:  

**Screening Information** vision testing requirements can be accomplished either through a screening (see below) or with a comprehensive eye exam (see other side). Screening provider must complete this section or parents may attach a copy of vision screening results given to them by a provider.

<table>
<thead>
<tr>
<th>Date of Vision Screening:</th>
</tr>
</thead>
</table>

Result: *(Please check)*:  
☐ Pass or  
☐ Fail  

Testing method: *(Please check)*  
☐ Vision Screening  
☐ Photo Screen  
☐ Other:  

Visual Acuity: *(if available)*  
☐ With Correction  
☐ Without Correction  

Right Eye___________Left Eye___________

Referral to eye health professional: *(Please check)*  
☐ Yes or  
☐ No  

Business Name/Source of Screening: *(please print name of provider office or if provided by school nurse, name of school)*  

Provider Name: *(please print)*  
Phone:  

Signature and Credentials of Provider:  
Date:  

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten and again before enrollment in the 3rd grade.  

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and 3rd grade and no later than six months after the date of the child’s enrollment in Kindergarten and 3rd grade.

RETURN COMPLETED FORM TO CHILD’S SCHOOL.
To the Parent or Guardian: The Iowa Optometric Association strongly recommends that to fully assess the health of your child’s visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. **If you choose to** take your child to an eye care professional for a comprehensive eye exam, this side of the form should be filled out and signed by the eye care professional and returned to the school nurse or teacher by your child.

### Visual Acuity

<table>
<thead>
<tr>
<th></th>
<th>At Distance</th>
<th>At Near</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Without correction</td>
<td>R20/ L20/</td>
<td>R20/ L20/</td>
</tr>
<tr>
<td>□ With present correction</td>
<td>R20/ L20/</td>
<td>R20/ L20/</td>
</tr>
<tr>
<td>□ With new correction</td>
<td>R20/ L20/</td>
<td>R20/ L20/</td>
</tr>
</tbody>
</table>

### External Eye Health

- □ Normal
- □ Other

### Internal Eye Health

- □ Normal
- □ Other

### Vision Analysis

<table>
<thead>
<tr>
<th>R</th>
<th>L</th>
</tr>
</thead>
</table>
| □ | □ | Normal eyesight
| □ | □ | Nearsighted (myopia)
| □ | □ | Farsighted (hyperopia)
| □ | □ | Astigmatism
| □ | □ | Amblyopia

- □ Other ________________________________

### Vision Correction Recommendations

- □ No correction necessary
- □ No change in present prescription
- □ New prescription needed

**To be worn for:**

- □ Constant wear
- □ Distance vision only
- □ As needed

To the Eye Care Professional: Please sign and date this form after the examination.

Dr. Name (Please Print) _______________________________________________________

Date_________________ Signature_________________________________________