



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SCHOOL VISION SCREENING FORM

IDENTIFYING INFORMATION		REASON FOR SCREENING
STUDENT NAME		<input type="checkbox"/> TEACHER REFERRAL
GRADE		<input type="checkbox"/> ROUTINE SCREENING
SCHOOL YEAR		TODAYS DATE

OBSERVATIONS

APPEARANCE	BEHAVIOR	COMPLAINTS
<input type="checkbox"/> RED EYES	<input type="checkbox"/> BLINKING	<input type="checkbox"/> CAN'T SEE BLACKBOARD
<input type="checkbox"/> GRANULATED LIDS	<input type="checkbox"/> WATERING EYES	<input type="checkbox"/> PRINT BLURS
<input type="checkbox"/> STYES	<input type="checkbox"/> SENSITIVE TO LIGHT	<input type="checkbox"/> DOUBLE VISION
<input type="checkbox"/> DISCHARGE	<input type="checkbox"/> RUB EYES	<input type="checkbox"/> HEADACHE
<input type="checkbox"/> SWELLING ABOUT EYES	<input type="checkbox"/> EXCESSIVE FROWNING	<input type="checkbox"/> NAUSEA
<input type="checkbox"/> HEAD TILT	<input type="checkbox"/> IRRITABILITY WHEN USING EYES	<input type="checkbox"/> DIZZINESS
<input type="checkbox"/> DROOPY LIDS	<input type="checkbox"/> SQUINTS OR SQUEEZES LIDS	<input type="checkbox"/> OTHER
<input type="checkbox"/> EYES OUT OF LINE	<input type="checkbox"/> HOLDS BOOK VERY CLOSE	
<input type="checkbox"/> STUMBLES/TRIPS OVER SMALL OBJECTS	<input type="checkbox"/> OTHER	

SCREENING DATE _____

WEARING GLASSES GLASSES BROKEN/LOST GLASSES AT HOME DOES NOT WEAR GLASSES

DISTANCE ACUITY	RIGHT 20 / LEFT 20 /	CHART USED
NEAR ACUITY	RIGHT 20 / LEFT 20 /	CHART USED
BINOCULARITY	TYPE OF TEST	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL

RE-SCREENING DATE _____

WEARING GLASSES GLASSES BROKEN/LOST GLASSES AT HOME DOES NOT WEAR GLASSES

DISTANCE ACUITY	RIGHT 20 / LEFT 20 /	CHART USED
NEAR ACUITY	RIGHT 20 / LEFT 20 /	CHART USED
BINOCULARITY	TYPE OF TEST	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL

PASS **REFER** **DATE OF REFERRAL** _____ **DATE EYE EXAM REPORT RECEIVED** _____

If unable to complete vision screening, please conduct a functional vision assessment.