Cranston Public Schools
Vision Screening

Name _____ Date _____

Grade _____ Room _____ School _____

Please have this form completed and returned to the school nurse so we may know the visual status of your child for our school records. Thank you for your cooperation.

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Visual Acuity: W/O Lenses RE_____ LE_____ Refractive Error _____

W Lenses RE_____ LE_____ Muscles _____

Pathology _____

Recommendations _____

Are glasses required for school? _____

_____

(Doctor's Signature) (Date)

H-20c
Revised 11/99