IOWA
Health and
Human Services

Certificate of Vision Screening

Pursuant with Iowa Code Chapter 641.52
Return completed form to child's school

Student Information (please print)

Student's Last Name:_____ Student's First Name:_____

Student Address: _____ Zip Code:_____

Date of Birth (M/D/YYYY):_____ Parent/Guardian Phone Number:_____

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.

Date of Vision Screening: _____

Result (Please check): ☐ Pass ☐ Fail

Testing Method (Please check): ☐ Vision Screening ☐ Photo Screening ☐ Other

Visual Acuity (If available): ☐ With Correction ☐ Without Correction

Right Eye: _____ Left Eye: _____

Referral to Eye Health Professional (Please check): ☐ Yes ☐ No

Business Name/Source of Screening (Please print name of provider office; or name of school if provided by the school nurse): _____

Provider Name (please print): _____Phone:_____

Signature/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.

Eye Exam Section

Pursuant with Iowa Code Chapter 280.7A

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 your child's school nurse or teacher.

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	**L**	
☐	☐	Normal Eyesight
☐	☐	Nearsighted (Myopia)
☐	☐	Farsighted (Hyperopia)
☐	☐	Astigmatism
☐	☐	Amblyopia

☐ Eye teaming difficulty
☐ Crossed eyes (Strabismus)
☐ Eye focusing difficulty
☐ Sensitivity to light
☐ Other

Vision Correction Recommendations
☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant Wear ☐ Near vision only
☐ Distance vision only ☐ As needed

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

Dr. Name (Please Print) _____

Date_____ Signature_____