

County \_\_\_\_\_ Screening Location \_\_\_\_\_

**PRESCHOOL VISION SCREENING RECORD**

CHILD'S NAME

CHILD'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

(Child's name used \_\_\_\_\_ School planned to attend \_\_\_\_\_ yr. mo.)

PARENT OR GUARDIAN'S NAME \_\_\_\_\_ TELEPHONE NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**BRIEF EYE HISTORY**

- |  |            |           |
|--|------------|-----------|
|  | <u>Yes</u> | <u>No</u> |
| 1. Has your child ever been examined by an eye doctor?   | _____      | _____     |
| When? _____ Reason _____   |            |           |
| 2. Name of eye doctor _____  |            |           |
| 3. When your child is ill or tired, do the eyes appear crossed or does one eye wander when looking at an object? | _____      | _____     |

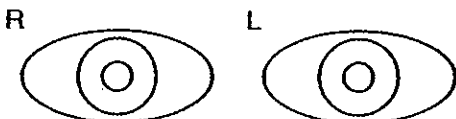
**DO NOT WRITE BELOW THIS LINE**

**I Visual Acuity**

Both eyes	0	1	2	3	4	5	6
Right eye	0	1	2	3	4	5	6
Left eye	0	1	2	3	4	5	6

PASSED                      FAILED

**II Corneal Reflection**



**III Cover-uncover Test: Near**

Right eye movement \_\_\_\_\_  
Left eye movement \_\_\_\_\_

**Cover-uncover Test: Far**

Right eye movement \_\_\_\_\_  
Left eye movement \_\_\_\_\_

**IV Eye History**

**V Symptom Referral**

State symptom(s) \_\_\_\_\_

**RESULTS**

- Passed
- Referred on Test
- Failed, Not Referred
- Rescreen for Visual Acuity

\_\_\_\_\_ Date of Rescreening Appointment

\_\_\_\_\_ Technician

\_\_\_\_\_ Date of Screening

Completion required to maintain necessary program records.  
DCH-0479 (10/98) (Formerly H-101P)

AUTHORITY: Act 368, PA 1978

**ATTENTION PARENT**

Your child was given the health department vision screening test and:

- Passed
- Failed - An eye examination by an ophthalmologist or optometrist is required.

Please present this certificate when enrolling your child in school for the first time. This is in accordance with the Michigan Public Health Code (Act 368 of 1978).

To School Administrator:

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Location

\_\_\_\_\_  
Date of Vision Screening

\_\_\_\_\_  
Qualified Vision Technician

\_\_\_\_\_  
Health Officer

Please retain this statement with other health records of child