3COMMUNITY SERVICES OF NORTHEAST TEXAS
HEAD START
VISION REFERRAL FORM

Date:

Dear Head Start Parent:

Head Start requires each student receive a vision screen after entry to school.

Your child _____ has failed the initial vision test with our SPOT Vision Screener.

It is required that he needs further testing by an optometrist and or your primary care physician.

Please take this form with you when your child is examined and ask the physician/optometrist to complete the bottom half. Return completed form to your child's Family Empowerment Advocate.

Thank you for your cooperation in this matter.

Dear Physician,

Please complete the following check list and return this form at your earliest convenience to:

Susan Horner
Head Start
Nutrition Coordinator
P. O. Box 427
Linden, Tx. 75563
Fax – 903-756-3254

I have examined_____on_____and find the following:
(*patient/student name)* *(date)*

[ ] No visual problem
[ ] A fully treatable problem
[ ] A partially treatable problem
[ ] A non-treatable problem

Visual Acuity: Right _____Left_____

Vision problem found: _____Glasses received : [ ] Yes [ ] No

Special Recommendations: _____
_____

_____ _____
Physician's signature Date