DEPARTMENT OF STATE HEALTH SERVICES
CERTIFICATE OF RECORD FOR
VISION SCREEN AND/OR EYE EXAMINATION

ATTENTION PARENT: The Vision and Hearing Screening Program requires that every child have an eye examination or an approved vision screening test prior to or within 120 days after entry into a Texas licensed child-care facility or school.

SCHOOL NAME____________________ CITY__________________ COUNTY_________________

CHILD'S NAME _________________________________ BIRTHDATE_____________ AGE_______

PARENT'S NAME _________________________________ TELEPHONE _____________________

ADDRESS____ CITY__________________ ZIP__________

The tests conducted to evaluate your child's vision are screens; they are not diagnostic. This means that if the child fails a screen, it is necessary for your child to be evaluated by a vision specialist, an ophthalmologist or an optometrist, to determine whether there is a vision problem. It also means that on some occasions a vision problem may exist that the screens will not identify.

** VISION SCREENER REPORT **

DISTANCE ACUITY SCREEN:

1ST SCREEN: DATE__________	2nd SCREEN: DATE__________	**COMMENTS/OBSERVATIONS:**
With Correction: □ Yes □ No Chart Used: Letter □ Right Eye 20/ "E" □ Left Eye 20/ H:O:T:V Machine □ PASS □ FAIL	With Correction: □ Yes □ No Chart Used: Letter □ Right Eye 20/ "E" □ Left Eye 20/ H:O:T:V Machine □ PASS □ FAIL	

HIRSCHBERT CORNEAL LIGHT REFLEX TEST	COVER AND UNCOVER	
□ Light reflection is centered or slightly toward the nose the same distance in each eye. □ Light reflection is not centered nor slightly toward the nose the same distance in each eye □ PASS □ FAIL	NEAR: 12-13 inches □ No Eye Movement □ Eye Movement □ PASS □ FAIL	FAR: 10 – 20 Feet □ No Eye Movement □ Eye Movement □ PASS □ FAIL

REFERRAL TO AN EYE CARE SPECIALIST (OPHTHALMOLOGIST OR OPTOMETRIST) DUE TO:

□ Distance Acuity Test
□ Hirschberg Corneal Light Reflex Test
□ Cover and Uncover Test
□ Observable Signs or Symptoms ____________________ (describe)
□ Parent/Doctor Request
□ Other: ____________________
□ UNSCREENABLE

DATE OF FINAL SCREEN: NAME OF SCREENER:

*** WAIVER OF REFERRAL ***

My child ____ is being seen by an eye care specialist,

____ (doctor's name), for the problem(s) indicated.

____ _________________________________
Parent's Signature Date

STUDENT'S NAME: ______________________ BIRTHDATE: ______________
SCHOOL: ______________________ GRADE: ____ TEACHER: ______________

THE INFORMATION ENTERED ON THIS FORM IS A RECORD OF SCREENING RESULTS AND IS NOT TO BE USED FOR DIAGNOSTIC PURPOSES.

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SWEEP-CHECK SCREENING

1. Instruct and condition each child appropriately for age/grade.
2. Screen 3 frequencies @ **25 dB**; begin screening @ 1000 Hz.
3. Identify responses with a "+"; identifying no response with a "-".
4. Sequence of tone presentations is numbered 1-3 below.

	EAR	1 1000 Hz	2 2000 Hz	3 4000 Hz	RESULTS
First Screen	R				_____ Pass
Date:	L				_____ Rescreen w/Sweep

COMMENTS: ____

Screener: ____

Children failing to respond to **ONE** (of the three) frequencies in **EITHER EAR** should be re-screened with another Sweep-Check within 3 to 4 weeks. (Signs or symptoms alone would be sufficient for referral.) Failure of **ONE** frequency in either ear on the second sweep check screen requires a referral or an **Extended Recheck**. If a failure of one frequency occurs when performing the extended recheck, a referral is required.

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	EAR	1 1000 Hz	2 2000 Hz	3 4000 Hz	RESULTS
Second Screen	R				_____ Pass
Date:	L				_____ Fail

COMMENTS: ____

Screener: ____

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EXTENDED RECHECK RESULTS

For each of the three frequencies listed, starting at **40 dB**, record the lowest level in decibels (dB) at which the child responds. Record the findings for both the right and left ears. A child should be referred to an appropriately licensed professional if any one of the three frequencies are recorded as greater than **25 dB** in either ear.

	EAR	1 1000 Hz	2 2000 Hz	3 4000 Hz	RESULTS
	R	dB	dB	dB	_____ Pass
Date:	L	dB	dB	dB	_____ Fail

COMMENTS: ____

Screener: ____

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(M-40)
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