



Vision Screening

(Report for Multidisciplinary Evaluation Team)

Name: _____ Date: _____

School: _____ Grade: _____

_____ (Date) Normal far/near point acuity in both eyes

_____ (Date) Normal with correction

Glasses

Contacts

_____ (Date) Failed far/near point acuity

_____ (Date) Failed with correction

Comments: _____

Nurse