

FREE School Vision Screening

To assist the technician, please complete the following:

Screening Date: _____ **Grade:** _____ **Teacher:** _____

Student's Legal Name _____ Birthdate _____

Parent Name: _____ Phone: _____

Mailing Address: _____

Has your child **ever** had an eye exam? YES NO

If YES, date of last exam: _____

When your child is ill or tired, do their eyes cross or one eye wander? YES NO

If yes, please explain: _____

Does your child wear glasses/contacts? YES NO

Condition of glasses: New Good Broken Lost

If you have any questions please call (269)926-7121 ext. 5292 Dawn, 5293 Melisa or ext.5693 Danielle

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