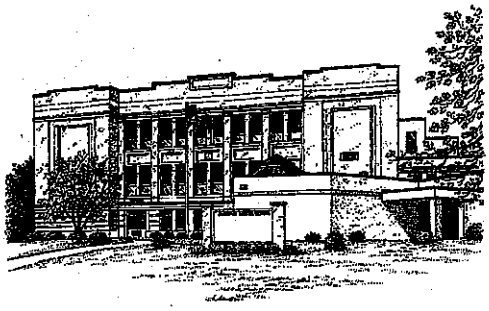

Sherman Central School

127 Park St. * PO Box 950 * Sherman, NY 14781-0950
Phone: (716) 761-6121 Fax: (716) 761-6119
Kaine M. Kelly- Superintendent
Michael V. Ginestre- Principal

March 3, 2014

Dear Parents,

Research indicates that access to a high-quality, Pre-Kindergarten programming for young children increases their chances to graduate from high school, attend college, and gain stable employment as adults. While Sherman Central School falls well below the average wealth ratio in New York State, we still must strive to provide our children with the same opportunities as children in wealthier districts. Our students cannot fall behind.

With that said, Sherman Central School is offering a **full-day** program for the 2015-2016 school year. Full-day pre-kindergarten will increase opportunities for our children to gain language skills, increase vocabulary, develop social skills, and build and acquire a love for learning that they will carry with them throughout their lives.

According to census information, your child is eligible for the program because he/she will be age 4 by December 1, 2015. Included in this letter are a Universal Pre-Kindergarten application, and health form with proof of immunizations. A copy of your child's birth certificate is also required and can be made at the district office. Your child is also required by New York State to have a physical before entering school.

In addition, your child is required to attend a Pre-Kindergarten screening where they will meet their prospective teacher. This screening will take place on April 14th, 15th or 16th. Teachers will also be available to answer any questions you may have. Please bring the forms as completed as possible with you to this screening. Any assistance needed in completing the paperwork will be provided that night. Call the main office at (716) 761-6121 to register for this event.

Sherman Central is extremely excited to offer this opportunity for the students of our district. With a high-quality, full-day Pre-Kindergarten program, our children will develop their literacy skills, improve decision-making and self-motivation, and acquire skills necessary for success now and throughout their lives.

Thank you for your time and consideration.

Sincerely,

Michael V. Ginestre -- Principal

Sherman Universal Pre-Kindergarten
Application Form

Child's Name: **Date of Birth:**

Parent(s)

Marital Status Married ___ Separated ___ Divorced ___ Single ___

Address *(Street)*
(City/State/Zip)

How long have you lived at this address?

Last place of residence if different than above

How often does the family move?

Telephone Numbers		
Home	*Work*	*Cell*

In case of **emergency** call: _____ Phone: _____

Second emergency contact: _____ Phone: _____

Child currently lives with *(circle any that apply):*

Mother, Father, Aunt, Grandmother, Grandfather, Foster Mother, Foster Father, Other ___

How long has child lived with the above circled adults? _____

Health History (Allergies, chronic medical conditions, medications/treatment, behavioral issues)

Primary Care Provider (Doctor): _____
Name Phone #

A HEALTH CERTIFICATE, A COPY OF THE CHILD'S BIRTH CERTIFICATE, AND IMMUNIZATION RECORD IS REQUIRED

Social History

Mother's Name	Age	Occupation/Where/Address/Phone
Father's Name	Age	Occupation/Where/Address/Phone

Adult Household Members	Monthly Income

Name of child(ren) and/or siblings also living in household	Date of Birth

Parent's level of education – please list highest grade completed including any college credit:

Mother:

Father:

Sherman Central School
127 Park Street Sherman, New York 14781
Health Office Phone: (716) 761-4814 FAX: (716) 761-6119

Dear Parent(s)/Guardian(s) of a new Universal Pre K student,

It is my pleasure to welcome you to Sherman Central School (SCS) District!

My name is Deanie Thorsell. I am a Registered Nurse and a Certified and Registered Respiratory Therapist with over 19 years of experience as a School Nurse. As the School Nurse for Sherman Central School, my job is to help in providing a healthy environment for your child while they are receiving their education, to be aware of their health status and to help with any medical issues as they arise, In addition, because I work for an educational institution, I feel my role is to also help educate our children in learning more about caring for themselves and making healthy choices.

To enter Pre-Kindergarten your child must have:

Documentation of a current Health Physical:

The form is enclosed for you to take to your primary care physician. ***This physical must be done between September 2, 2014 and September 2, 2015 to be considered current.*** If your child has had a physical, during this time period, you may contact your Physician and ask that they Fax the report to school now. Our Fax number is (716) 761- 6119.

Immunization Record:

Immunizations must be current based on NYS Public Health Law requirements for entry and attendance. See the enclosed list of requirements. Your Physician can also FAX this information to the school. If your child has a Medical Exemption for any vaccination your physician must send a signed document listing the Medical exemptions and reason for them. This form will need to be submitted annually. If you have not immunized your child due to religious conviction you must request and submit the Religious Exemption forms. These are available through Tracie Cederquist, in the Administration office, or online (www.Sherman.wnyric.org).

Student Health History:

Please complete this enclosed form for your child's health record. We use a computerized Health Record, called SNAP, which is very helpful in keeping records and accurate health information on your child. This information enables us to best provide for any possible medical needs, as well as modify educational needs, while your child is in our care. **NOTE: If your child has any food allergies, such as milk, which may require modification of a cafeteria meal, we will need an order from your physician. This may also be sent with the Health Certificate.**

Regarding Medications:

NO Prescription or Over the Counter Medications can be administered in the Health Office unless a physician's order and parent's permission form is on file. **Students are not to bring any medications (including cough drops) to school for a variety of safety reasons.** If your child is in need of medication at school, please contact me or see the school website for appropriate documents and procedures. If your child requires an Over the Counter medication, a telephone call to your primary care physician can be made to request a short term order be faxed to the school. This is not a problem and doctor's offices are very accustomed to this type of request, when needed. Otherwise medication can often be timed before and after school. Please don't hesitate to contact me, at any time, with questions regarding medication.

Communications from your Primary Care Physician:

Documents may require your signing an Authorization for Release of Medical Information form. Please talk with your primary care physician about this and consider signing the form at their office, on behalf of Sherman Central School Health Office. This will allow your doctor to release immunization, health appraisal, medication orders and updates on medical conditions and education modifications needed. This will save a tremendous amount of time and help provide timely, accurate care for your child. There is an Authorization form on our Website.

In the event that your child becomes ill or injured during the school day, I will use the contact numbers on file for your child to inform you. PLEASE be sure to keep these numbers current.

I have also included permission forms for Dental and Vision Screening. Please review, sign and return if you are interested in either of these services. You will be informed when these clinics occur.

I look forward to getting to know your child/children and being a part of both their medical and educational experience. Please don't hesitate to contact me with any concerns or changes that arise.

Sincerely,

Deanie B. Thorsell, Rn, RRT

Deanie B. Thorsell, RN, CRTT, RRT
dthorsell@sherman.wnyric.org
(716) 761-4814

SHERMAN CENTRAL SCHOOL
STUDENT REGISTRATION FORM
(Please complete all information)

Office Use Only
Student# _____ Family # _____
Homeroom _____ Grade _____
Enrollment Date _____
Birth & Immunization Records _____
Dental Records _____

_____ _____ _____ _____ Grade_Level_____
STUDENT'S LEGAL LAST NAME **Jr.,II,etc.** **FIRST NAME** **MIDDLE NAME** **GENDER:** male___ female___

Birth Date_____ Birth City _____ State_____ Country _____ STUDENT'S SS#_____-_____-_____

Street/RD Address_____ City_____ PO Box Address_____

Home Telephone_____ Unlisted? Yes___ No___ [Message phone _____ Name _____]

Name of last school attended:_____ Date left_____ Phone (___)_____

Address of last school: Street_____ City_____ State_____ Zip_____

Has student ever attended Sherman Central School before? Yes___ No___ If yes what year? _____

Date of 1st Polio Shot_____ **Student's Cell Phone #**_____

Ethnic Origin
Am.Indian___ Asian___ Afr-Am.___ Caucasian___ Hispanic___

Language spoken in home:
Eng.___ Spanish___ Other_____

(Elementary Students Only) - NAME OF PRESCHOOL ATTENDED_____

FAMILY INFORMATION

PRIMARY FAMILY

***Guardian living with student* (If other than natural parent, PROOF OF GUARDIANSHIP must be provided)**

_____ _____ _____ Relationship to child: ___natural parent ___ step ___ foster ___ other (list)_____
Last Name *First Name* *MI*

Employer _____ Shift_____ Work Phone (___) _____ Ext._____

Cell Phone _____ Pager_____ E-Mail _____

SPOUSE / OTHER (living with student)

_____ _____ _____ Relationship to child: ___natural parent ___ step ___ foster ___ other (list)_____
Last Name *First Name* *MI*

Employer _____ Shift_____ Work Phone (___) _____ Ext._____

Cell Phone _____ Pager_____ E-Mail _____

Maiden Name of child's natural mother _____

SECONDARY FAMILY **- COMPLETE ONLY IF PARENTS ARE DIVORCED / SEPARATED AND THERE IS JOINT CUSTODY**

_____ _____ _____ Relationship to child: ___natural parent ___ step ___ foster ___ other (list)_____
ast Name *First Name* *MI*

ddress_____ Home Phone _____

mployer _____ Shift_____ Work Phone (___) _____ Ext._____

ell Phone _____ Pager_____ E-Mail _____

POUSE / OTHER

_____ _____ _____ Relationship to child: ___natural parent ___ step ___ foster ___ other (list)_____
st Name *First Name* *MI*

nployer _____ Shift_____ Work Phone (___) _____ Ext._____

ll Phone _____ Pager_____ E-Mail _____

PLEASE COMPLETE SIDE 2

EMERGENCY INFORMATION: The following person(s) are to be contacted in this order if parent cannot be reached:

Name	Relationship	Home Phone	Cell/Work #	Address
1st				
2nd				
3rd				

Besides parents and the persons listed above, my child MAY BE PICKED UP AT SCHOOL BY:

Name	Relationship	Home Phone	Cell/Work #	Address

SIBLINGS: List all other children living in your household for census purposes:

Last Name	First Name	Birthdate	Gender M / F	School Attending

STUDENT SHOULD **NOT** *BE RELEASED TO:*

(NOTE: IF THIS PERSON IS THE BIOLOGICAL PARENT, THE SCHOOL MUST HAVE LEGAL DOCUMENTATION ON FILE IN ORDER TO DENY THE BIOLOGICAL PARENT ACCESS)

NAME_____

RELATIONSHIP TO CHILD_____

What type of **MEDICAL COVERAGE** does the student have?

___ Blue Cross/Shield ___ Univera ___Independent Health
___ Community Blue ___ Fidelis ___Child Health + ___ Family Health +
___ Medicaid ___ No Health Insurance ___Unknown

Does the student have a regular doctor or clinic?

____NO ____YES – Health Care Provider _____

DID YOUR CHILD RECEIVE ANY OF THE FOLLOWING SERVICES AT THE FORMER SCHOOL?

____Speech ____Writing ____Remedial Math ____Remedial Reading ____Occupational Therapy ____Resource Room/Inclusion (I.E.P.)

____Gifted/Talented ____Special Ed. (I.E.P.) ____Counseling ____Physical Therapy ____Free Lunch ____Reduced Lunch

____ Medication / Treatment at school (please indicate in the section below)

ARE THERE OTHER INSTRUCTIONS OR RESTRICTIONS THE SCHOOL SHOULD KNOW ABOUT? (I.E. allergies, chronic medical conditions, medications / treatment, behavioral issues, etc.)

N THE EVENT OF AN EMERGENCY EVACUATION OF THE SCHOOL, MY CHILD IS TO PROCEED AS FOLLOWS:

	Walk or Bus (Bus #?)	Name	Relationship to Child	Contact Number(s)	Address
Choice					
Choice					

ARENT/GUARDIAN SIGNATURE_____ DATE_____

If any of the information you have provided changes during the school year, please be sure to notify the school office immediately.

Sherman Central School
STUDENT HEALTH HISTORY

Name: _____ Age: _____ Birthdate: _____

Address: _____ Phone Number: _____

Date of Interview: _____ Individual providing health history: _____

Primary Care Provider: _____ History of Concussion (MTBI) ❑ Yes ❑ No

Dentist: _____ Braces: ❑ Yes ❑ No

Eye Doctor: _____ Eye Glasses/ Contacts: ❑ Yes ❑ No Distance Near

Color Blind: ❑ Yes ❑ No

History:

Were there any issues during pregnancy, labor and/or delivery for this child? ❑ Yes ❑ No
If yes, please describe: _____

Does this child have an ongoing health concern? (asthma, diabetes, etc.) ❑ Yes ❑ No
If "yes", please describe: _____

Does this child have any allergies? ❑ Yes ❑ No
If "yes", please list: _____
Has the allergy required emergency treatment? ❑ Yes ❑ No
If "yes", please explain: _____

Are the child's immunizations up to date? ❑ Yes ❑ No
Additional immunizations required: _____ given? _____

Is there a history of any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No
If "yes", please describe: _____

Are there any current medical concerns/injuries? ❑ Yes ❑ No

❑ Head _____ ❑ Eyes _____ ❑ Nose _____
❑ Ears _____ ❑ Throat _____ ❑ Neck _____
❑ Chest _____ ❑ Respiratory _____
❑ Cardiovascular _____ ❑ Gastrointestinal _____
❑ Genitourinary _____ ❑ Neurological _____
❑ Muscloskeletal (include any past fractures,sprains etc.) _____

Does this child take any medication regularly at home? ❑ Yes ❑ No
Require medication at school? ❑ Yes ❑ No *If Yes – form required*

Please list any additional concerns or information: _____

_____

Describe child's nutritional pattern and dietary intake: _____

List any significant medical concerns in family:

❑ Mother _____ ❑Father _____
❑ Siblings _____ ❑ Grandparents _____
❑ Other _____

Who lives with the child in his/her primary household? _____

Does child spend a significant amount of time in another household? ❑ Yes ❑ No

If "yes", please describe: _____

Who has legal custody of this child? _____

Describe any custody arrangements: _____

Any additional concerns or pertinent information:

Signature and Title of Interviewer: _____ Date: _____

Signature of person giving Health History _____

(Print Name and relation)_____ Date: _____

Forms provided to Parent:

❑ Yes	❑ No	Health Certificate/Appraisal Form
❑ Yes	❑ No	Permission to give Medication at School to be returned by parent with appropriately labeled medication(s)
❑ Yes	❑ No	Sports Physical and Health Screening Form
❑ Yes	❑ No	Emergency Care Plan FOOD ALLERGY to be returned by parent with appropriately labeled medication(s)
❑ Yes	❑ No	Medical Information Release Form
❑ Yes	❑ No	Other: _____

Forms requested from Parent:

❑ Yes	❑ No	Immunization Record
❑ Yes	❑ No	Current Health Physical from Primary Care Physician (within 12 months)
❑ Yes	❑ No	Orders for Food Allergy Modifications - Cafeteria
❑ Yes	❑ No	Other: _____

2014-15 School Year

To our knowledge this is also current for 2015-2016. ☺

New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES: Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee for Immunization Practices (ACIP).
This schedule reflects the minimum doses that are required for grades kindergarten through 12. Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. See footnotes for specific information for each vaccine.

Dose requirements MUST be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten	Grades 1 through 5	Grade 6	Grades 7 through 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap)[2]	4 doses	4 to 5 doses (See footnote 2b)	4 to 5 doses (See footnote 2b-e)	3 doses (See footnote 2c-e)	3 doses (See footnote 2d-e)
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3] (Required only for students enrolling in grades 6-12 who have not previously received a Tdap at 7 years of age or older)	Not applicable	Not applicable	Not applicable	1 dose (See footnote 3b)	1 dose (See footnote 3b)
Polio vaccine (IPV/OPV)[4]	3 doses	3 to 5 doses (See footnote 4b-d)	3 doses	3 to 5 doses (See footnote 4b-d)	3 doses
Measles, Mumps and Rubella vaccine (MMR)[5]	1 dose	1 dose	2 doses 2 doses required by age 7	2 doses	2 doses
Hepatitis B vaccine[6]	3 doses	3 doses	3 doses	3 doses	3 doses
Varicella (Chickenpox) vaccine[7]	1 dose	2 doses	1 dose	2 doses	1 dose
Haemophilus influenzae type b conjugate vaccine (Hib)[8]	1 to 4 doses (See footnote 8a-g)	Not applicable	Not applicable	Not applicable	Not applicable
Pneumococcal Conjugate vaccine (PCV)[9]	1 to 4 doses (See footnote 9a-f)	Not applicable	Not applicable	Not applicable	Not applicable

Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

UNIVERSITY OF BUFFALO
STATE UNIVERSITY OF NEW YORK

Pediatric Dentistry
School of Dental Medicine
137 Squire Hall
Buffalo, NY 14214-3008
(716) 829-2723

UB School of Dental Medicine Mobile Dental Van

"DENTAL CARE FOR KIDS"

PATIENT INORMATION DATE: _____/_____/_____

PLEASE PRINT CLEARLY

Child's Name: _____ Sex: M / F DOB: _____/_____/_____

Address: _____ City: _____, NY

Zip Code: _____ Phone: ( ) _____ Child's SS#: _____

Child's School: _____ Teacher's Name: _____

Parent/Guardian Name: _____ Sex: M / F DOB: _____/_____/_____

Address: _____ City _____, NY Zip Code: _____

SS#: _____ Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

TYPE OF DENTAL COVERAGE (PLEASE CIRCLE ONE):

MEDICAID UNIVERA (CHP) NO DENTAL COVERAGE

- PLEASE ENTER ID #: _____
  (Can be found on top left corner of child's benefit card)
- Sequence #: _____

YOUR CHILD CANNOT BE SEEN BY THE DENTAL VAN IF THE ABOVE INFORMATION IS NOT RECEIVED BEFORE HIS OR HER APPOINTMENT.

HEALTH INFORMATION

Is your child in good health? ____ Yes ____ No

Name of child's medical doctor: _____

Is your child taking any medications? ____ Yes ____ No

If yes, name of medication(s): _____

If this is not your child's first dental visit, has it been over 6 months since their last visit?
____ Yes ____ No ____ Not sure

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

SHERMAN CENTRAL SCHOOL
PO BOX 950, SHERMAN, NY 14781
Phone: (716) 761-6121 Fax: (716) 761-6119

HEALTH CERTIFICATE / APPRAISAL FORM

**Name: _____ **Date of Birth: __/__/__ **Gender: ☐ M ☐ F **Grade: _____ * **Sports: _____

HEALTH HISTORY

**Significant Medical/Surgical History: ☐ See attached _____

**Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Seasonal: _____
☐ NKDA ☐ Medication: _____ ☐ Other: _____

PHYSICAL EXAM / IMMUNIZATIONS *Items in BOLD are required*

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Date of Exam:** _____

Body Mass Index: _____ _____. _____

Weight Status Category (BMI Percentile):

☐ **less than 5th** ☐ **5th through 49th** ☐ **50th through 84th**
☐ **85th through 94th** ☐ **95th through 98th** ☐ **99th and higher**

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** **Tanner:** I. II. III. IV. V. **Scoliosis:** ☐ **Negative** ☐ **Positive:** _____

Specify any abnormality (use additional page if needed): _____

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal: _____

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications on attached list.

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

Optional Information, if known: **Specify current diseases:** ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2
☐ Hyperlipidemia ☐ Hypertension ☐ Other: _____
(Stamp below)

Provider's Signature: _____ Phone: _____

(PRINT) Provider's Name/Address: _____ Fax: _____

**Parent Signature: _____ Date: _____

**** PARENTS PLEASE COMPLETE THESE AREAS**

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days or a concussion (MTBI) that will require review by private healthcare provider and the school medical director. *Rev. 12/13 DBT, RN*

Lions SEE, Inc.
At the Ira G. Ross Eye Institute
1176 Main St., Buffalo, New York 14209
(716) 881-7915 (716) 887-2991 Fax
md20lionsee@gmail.com
www.lionsSEE.org

For office Use Only

Preschool Vision Screening

♥Consent Form♥

Consent of Parent/Guardian

Free vision screening will be offered to your child by the Lions Club Organization in conjunction with the Lions SEE Program at the Ira G. Ross Eye Institute. The screening provides instant photographs or a digital reading of your child's eyes to determine the presence of eye disorders including far and nearsightedness, astigmatism, and anisometropia (unequal refractive power), and media opacities (i.e. cataracts). No physical contact is made with your child and eye drops are not necessary. The screening is approximately 85-90% effective in detecting problems that can cause decreases in vision.

I, the undersigned, hereby give permission for my child, named below, to participate in the screening event. I understand the following regarding this program:

1. The information obtained from this vision screening is preliminary only, and does not constitute a diagnosis of vision problems.
2. There is no charge to participate in the vision screening process.
3. I understand that I am responsible for arranging a full eye exam if my child has been referred as a result of the vision screening. I give permission for my doctor to share the evaluation results with Lions SEE Program at the Ira G. Ross Eye Institute.
4. I will not hold either the Lions Clubs Organization or Lions SEE Program at the Ira G. Ross Eye Institute or the school or facility where the screening is held accountable for any errors of commission, omission or other misdiagnosis.

PLEASE PRINT

_____ _____ _____ _____

Name of Parent or Guardian *Signature* *Date* *Child's First, Middle Initial and Last Name*

_____ _____ _____ _____ _____ _____

Child's date of Birth *Age* *Address* *City* *Zip Code*

Home Phone (____)_____ *2nd Phone* (____)_____

Do Not Complete Form *if your child is currently under Vision treatment- Screening every 2 years is sufficient-*

Results If you have any questions about your results contact (716) 881-7915.

____ **PASS** (We are unable to detect a vision problem at this time. The screening is not a substitute for a complete exam. Consult your eye care professional if you suspect a vision problem.)

____ **REFER** Your child should be examined by an eye care Professional because he/she may have the following condition that has the potential to cause poor vision in one or both eyes:

__**Anisometropia** *(Difference between eyes; can cause poor vision in one eye)*
__**Astigmatism** *(Possible need for glasses)*
__**Hyperopia** *(High Farsightedness (Can contribute to eye crossing)*
__**Myopia** *(near Sightedness)*
__**Other** _____
__**Unreadable**, *Refer (we were unable to obtain acceptable reading)*

☐Focus *(top/bottom)* ☐ 4-8 mm pupils *(top/bottom)* ☐fixation *(top/bottom)* ☐ 4 pupils *(top/ bottom)*

If your child is referred from this screening, **please take them to see an ophthalmologist or optometrist** in your area.
Bring with you this form along with the Evaluation Sheet (Included in this packet) to your appointment for the eye doctor to complete.

April 2011 KS

The Volunteer Will Staple Your Child's Vision Screening Photo Or Welch Allyn SureSight Digital Printout Here