MADISON METROPOLITAN SCHOOL DISTRICT

Dear Parent or Guardian:

A vision screening test was given to _____,

Student Number _____, on _____

at _____ School.

Based on the results of the vision screening program at school we recommend that your child has an eye examination by an eye doctor. Good vision is important for all students so that they are ready and able to learn. Remember, children and adolescents who have poor vision, may have a harder time in school, sports, social situations and life.

Your Child's Results:

- ❑ Did not pass the eye chart vision screening
- ❑ Right eye
- ❑ Left eye

Comments / Observations:_____

What you should do:

1. Make an appointment for your child with an eye doctor
2. Bring the Vision Referral Letter to the eye doctor
3. Ask the eye doctor to complete the Record of Examination on the back and FAX it to your school nurse.

How to make the appointment:

1. If you have Private Vision Insurance Plan - contact your plan to find an eye doctor.
2. If you have a BadgerCare Plus HMO – contact your child's HMO's Customer or Member Service for a list of eye doctors that are under your plan.
    i. Dean Health Plan 1-800-279-1301
    ii. GHC-SCW 1-800-605-4327
    iii. Quartz Health Insurance 1-800-362-3310
    iv. United Healthcare 1-800-504-9660
    v. Anthem Blue Cross Blue Shield 1-855-690-7800
3. **Contact your school nurse if you are not able follow-up with your insurance plan or do not have vision insurance or have questions. Phone number: _____**

_____

School Nurse

MADISON METROPOLITAN SCHOOL DISTRICT

TAKE THIS FORM TO THE EYE DOCTOR TO COMPLETE PROFESSIONAL REPORT OF EYE EXAMINATION

Child's Name: _____ Date of Birth: _____

Date of Exam: _____

Provider Name: _____

Provider Facility (Address, Phone number, and Fax):

1. Diagnosis:
- ❑ Normal
- ❑ Amblyopia
- ❑ Strabismus
- ❑ Refractive Error:
- ❑ Myopia
- ❑ Hyperopia
- ❑ Astigmatism
- ❑ Other_____

2. Glasses Needed: Yes _____ No _____ Change in Prescription _____

3. Recommended Usage of Glasses:
   a. All the time _____
   b. Distance _____
   c. Reading _____
   d. Other _____

4. Other Treatment: _____

5. Follow-up visit recommendations: _____

PARENT AUTHORIZATION FOR RELEASE OF INFORMATION
I, the parent/guardian of the above named child, authorize the exchange of information between the eye care professional and my child's school nurse. I understand that this form will be faxed to the school nurse so they may assist in assuring the above recommendations can be followed to help my child's learning. PARENT/GUARDIAN SIGNATURE_____ Date_____

PLEASE RETURN TO SCHOOL NURSE
School Nurse:
Phone:
FAX