TEXAS Health and Human Services | Texas Department of State Health Services

Certificate of Record for Vision Screen and/or Eye Examination

Child's Name_____Birthdate_____Age_____

DISTANCE ACUITY SCREEN

1st Screen (Date): _____	2nd Screen (Date): _____
With Correction: ☐ Yes ☐ No	With Correction: ☐ Yes ☐ No
Chart Used: ☐ Sloan Letter ☐ HOTV	**Chart Used:** ☐ Sloan Letter ☐ HOTV
Result: (R) Eye **20/** (L) Eye **20/**	**Result:** (R) Eye **20/** (L) Eye **20/**
Pass ☐ **Rescreen** ☐ **Fail/Refer** ☐	**Pass** ☐ **Fail/Refer** ☐

Comments/Observations:

AUTOMATED SCREENING DEVICE

Type of Device: ☐ Photo Screener ☐ Auto-Refractor ☐ Other

Result: ☐ PASS ☐ FAIL

HIRSCHBERG CORNEAL LIGHT REFLEX TEST

☐ 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.

Result: ☐ PASS ☐ FAIL

COVER AND UNCOVER TEST

NEAR: 12 to 13 inches ☐ No Eye Movement ☐ Eye Movement

FAR: 10 to 20 feet ☐ No Eye Movement ☐ Eye Movement

Result: **Near:** ☐ PASS ☐ FAIL **Far:** ☐ PASS ☐ FAIL

REFERRAL REASON (If applicable)

☐ Distance Acuity Screen
☐ Automated Screening Device
☐ Hirschberg Corneal Light Reflex Test
☐ Cover and Uncover Test
☐ Parent/Doctor Request
☐ Unable to Screen
☐ Other:

Observable Signs or Symptoms (describe):

SCREENING CERTIFICATION

Signature of Screener:

Date: | Print Name of Screener:

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 public or private preschool or school, licensed child care center, or child care home.

The tests conducted to evaluate your child's vision are screens; they are not diagnostic. This means that if your child fails a screen, it is necessary for him or her to be evaluated by his or her primary care provider 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.

*** **WAIVER OF REFERRAL*****

My child _____ (name of child) is being seen

by an eye care specialist, _____ (doctor's name), for

the problem(s) indicated.

Parent's Signature_____Date_____

If "Waiver of Referral" is complete, it should be returned to the school.