CLEAR FORM

CALIFORNIA-HAWAII ELKS MAJOR PROJECT, INC.

Since 1950
Elks Program For Children With Disabilities

(* = MANDATORY INFORMATION)
(Print Or Type)

Child's
***Last**: _____
***First**: _____
***Sex**: ( ) Female ( ) Male
***DOB**:

***Guardian consent has been given to perform this screening.** ____ **(Initial)**

Guardian: _____
Mailing Address: _____
City, State Zip: _____
Phone # :

Your child participated in a screening provided at no charge through donations by the Elks of California and Hawaii. Please understand that this screening is not a substitute for a doctor's eye examination.

DISPOSITION

( ) **YOUR CHILD'S VISION SCREENING RESULTS APPEAR AGE APPROPRIATE.**
( ) But see recommendations and/or comments below.

( ) **THERE APPEARS TO BE A PROBLEM. NOTE RECOMMENDATIONS BELOW.**

( ) Visual acuity tested with glasses: ( ) appears appropriate
( ) suggests checkup, unless monitored by Eye Doctor

( ) This screener was unable to complete the screening.

RECOMMENDATIONS

( ) **REFERRAL TO EYE SPECIALIST. PLEASE REFER TO THE ATTACHED FORM.**

( ) **IMMEDIATE FOLLOW-UP IS INDICATED. PLEASE CALL VISION SCREENER AT (925) 481-2353**

( ) Referral to eye specialist is not being made because this Screener was told by _____
( ) that your child is under the care of a physician/specialist.
( ) that your child has prescription glasses but the glasses were not available at this screening. The Visual Acuity test suggests glasses may need to be worn on a regular basis. Note visual acuity results recorded within the Vision Acuity Section.

( ) Check observations listed within the observation section. **IF CONDITION CONTINUES, SEE YOUR ( ) EYE SPECIALIST OR ( ) FAMILY PHYSICIAN.**

( ) Recommend professional eye exam/screening ( ) before Kindergarten ( ) in ____ months.

COMMENTS

( ) Note _____ line difference between eyes recorded in visual acuity section.

( ) Child was previously referred on _____

( )

SCREENING RESULTS

CERTIFIED PEDIATRIC VISION SCREENER
Juliana Conde _____
(925) 481-2353

SITE: **6698** Valley Christian Schools

DATE SCREENED: ____ / ____ / **17**

VISUAL ACUITY tested at 10 feet

FAR VISION: ( ) PASSED ( ) REFERRED ( ) SEE COMMENTS

Chart Used: ( ) HOTV ( ) Tumbling E ( ) Sloan_____

( ) Method other than patching used to occlude eye.

( ) Child was wearing glasses.

B: 20/ R: 20/ L: 20/

Rescreened: _____ / _____ / _____ ( ) same day

B: 20/ R: 20/ L: 20/

NEAR VISION: ( ) PASSED ( ) REFERRED
Checked using +2.25 hyperopia glasses for children 6 years or older

ASSESSMENT / MUSCLE TESTS ( ) PASSED ( ) REFERRED

(√) Cover/ Uncover Near

(√) Alternate Cover/Uncover Near

(√) Versions

(√) Convergence

(√) Red light reflex

( )

OBSERVATIONS (Key: B=both eyes, R=right eye, L=left eye)

( ) Red Eye ( ) Strains/Squints ( ) Tilts Head
( )