Northridge Local Schools

Educating Today for Tomorrow's Success

Dear Parent(s):

The Amended Substitute House Bill 95 passed in 2003 requires students initially identified with disabilities to have an eye exam beginning in the fall of 2004. This exam is very important since most learning is through vision. An eye exam performed by an eye doctor, optometrist or ophthalmologist can detect vision problems. The appointment with the eye doctor should be made within 90 days after your child is initially identified with disabilities. If your child has had an eye exam within the previous nine months, the requirement is waived.

An estimated 85% of students already have some form of insurance that will cover the eye exam. However, if you do not have coverage and cost is an issue, you may contact the Ohio Optometric Association for assistance. Their number is 1-614-781-0708. A list of eye doctors by zip code can be accessed at www.ooa.org.

Once the eye exam has been completed, please send the report to your building's school nurse.

Thank you for attending to this need.

Sincerely,

Northridge Special Education Department

Report of Professional Eye Examination to the School
Please return completed form to school

Student name ______________________________ Date of birth ______________

Grade _________ Date of Examination ________

Report of Eye Examination:

Visual Acuity: Distance: Without correction: R___________ L___________
With correction: R___________ L___________

Visual Acuity: Near Without correction R___________ L___________
With correction R___________ L___________

Peripheral vision:
If fields are restricted, indicate degree and location: ______________________________

Diagnosis: ____
Plan:

No treatment at this time Eye glasses Contact Lenses
Patch Other ______________________________________

Please indicate when or under what conditions corrective lenses/patch should be worn:
____

Requirements: ______ Correction not required
______ Correction prescribed
______ Glasses ______ Contact Lenses

Corrected Visual Acuity: R 20/ _________ L 20/ _________

Frequency of Classroom Use:
_______ Wear at all time. _______ Wear for distance only
_______ Wear for reading tasks only _______ Other (specify

Physical Education:

________ Wear for physical education ________ Remove for physical education

Signature ____ (O.D.) (D.O.) (M.D.)

Print Name ____

Practice Name ____

Address ____

City, State, Zip ____

Phone Number ____________________ Fax Number ____________________