NORTH HUNTERDON HIGH SCHOOL
1445 Route 31
Annandale, NJ 08801
Phone: 908-713-4171 or Fax: 908-713-4403

School Health Services Vision Referral

Student's Name______________________________________Grade______________Date______________

Dear Parent/Guardian,

________Your son/daughter's physical does not have the **required** vision section completed; this may be done by your family doctor or an ophthalmologist/optometrist.

________The vision is above a 20/40 acuity, please obtain further evaluation by an ophthalmologist or optometrist and submit the corrected vision results on the form below.

***If your student is playing a sport, they will not be cleared until we have the updated information.

Findings: WITHOUT GLASSES

FAR: R
L

NEAR: R
L

Findings: WITH GLASSES

FAR: R
L

NEAR: R
L

COMMENTS:____

Your cooperation is appreciated.
North Hunterdon High School Nurses/Athletic Trainers

REPORT FROM EYE DOCTOR
SUMMARY OF FINDINGS

1. Diagnosis ____
2. Visual Acuity: Without Glasses:
   FAR: R L
   NEAR: R L
   With Glasses:
   FAR: R L
   NEAR: R L
3. Recommendations:
   A. New glasses prescribed Yes_____ No_____
   B. Old glasses satisfactory Yes____ No_____
   C. Glasses should be worn constantly Yes____ No_____

Follow-up and further recommendations____

Date of Examination______________

Examiner________________________________
Address_________________________________

PLEASE RETURN THE COMPLETED FORM TO THE HEALTH OFFICE AT THE ADDRESS LISTED ABOVE. *(Revised 1/08)*