NOCAC CHILD DEVELOPMENT PROGRAMS

Head Start
Vision Report Form

Dear parent – take this form to your doctor. Your child has failed our screen and needs professional evaluation by this date: _____. Ask your child's teacher if you do not know where to take him or her. Thank you!

Dear Provider – please complete this form and mail it to us as soon as possible after you see the child. Our federal regulations require that we document the visit. We appreciate your help!

Child' s name	Date of Referral
Center	
Reason for Referral (screening failed or type of symptom):	

Eye Specialist Section

Visual Acuity without glasses R_____ L_____ B_____ with glasses R_____ L_____ B_____
Summary of vision problems
Recommendation
Recommendation for Teacher
Additional treatment necessary? _____ yes _____no I wish to see the child again _____ yes _____ no When _____
Comments

Specialist Signature:	**Return form to:** Disabilities/Intervention Coordinator 1933 E. Second Street Defiance, Oh. 43512
Address	
Date of Service	

White – Parent Yellow – CO File

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