starpupils™
healthy eyes for healthy futures

Prevent Blindness Georgia®
Our Vision Is Vision®

Suite 200
739 West Peachtree Street NW
Atlanta, GA 30308-1137
(404) 266-2020 tel
(404) 266-0860 fax
(800) 477-4448 toll free

Dear Parent,

❑ **Your child FAILED** today's vision screening and may not be able to see as well as he or she should. See screening results on the back. It is important that vision problems be detected and corrected early. They can lead to permanent vision loss or blindness, poor performance in school, short attention span, clumsiness and/or lack of confidence.

1. Make an appointment with an **eye doctor** now.
2. **Take this form to the eye doctor. Ask the doctor to complete the exam report on the back and return the completed form to Prevent Blindness Georgia.**
3. Contact Prevent Blindness Georgia at 404-266-1548 if you have questions.

If your child has prescription glasses but was not wearing them for the screening, he/she needs to wear them to school in order to see well enough to learn.

❑ **Your child failed today's vision screening WITH his/her glasses. See screening results on the back.**

If your child is under an eye doctor's care, you may already be aware of these concerns. However, you should contact the eye doctor to discuss these screening results if they are not what you expect.

❑ **Your child was unable to complete today's vision screening** because he or she was uncomfortable, uncooperative or unable to respond appropriately. Untestable children are more likely to have vision problems. If you cannot have your child rescreened within six months, schedule an appointment with an eye doctor.

We recommend that you follow up this screening with an eye exam within two months. If your child does have a vision problem, his/her vision may continue to worsen until treatment is begun.

The ABC's of Possible Eye Problems in Children
If your child shows one or more of these signs, have your child seen by an eye doctor without delay.

Appearance	Behavior	Complaints
• Crossed or misaligned eyes • Inflamed or watery eyes • Recurring sties (infections) on eyelids • Color photos of eye show white reflection instead of typical red or no reflection • Red-rimmed, crusted or swollen eyelids • Droopy eyelid	• Rubs eyes excessively • Shuts or covers one eye • Squints or frowns • Tilts or thrusts head forward • Has difficulty with reading or other close-up work • Holds objects close to eyes • Blinks more than usual or is irritable when doing close-up work • Is rigid when looking at distant objects	• Eyes itch, burn or feel scratchy • Cannot see well • Blurred or double vision • Dizziness, headaches, or nausea following close-up work • Sensitivity to light

Your child's vision screening was funded in part by donations from individuals, foundations and corporations.
To vision screen another child, please give to Prevent Blindness Georgia at www.pbga.org.

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Child's Name_____ Screening Date_____

Screening Location_____ Screener_____

Dear Doctor:

This child was screened by a Prevent Blindness Georgia certified vision screener and has been referred for a professional eye examination. Please help us evaluate this program by completing and returning this form to us at the address or fax number listed above, or scan and email it to lirby@pbga.org. All results are confidential and for statistical use only.

Vision Screening Results/Reason for Referral ___With glasses ___Without glasses

❑ Appearance, behavior or complaint symptoms observed:_____

_____

❑ Failed Lea Symbols® Distance Visual Acuity: Right Eye 20/_____ ; Left Eye 20/_____

(Acuity > 20/50 for 3 year old, > 20/40 for 4-5 year old, or two line difference within passing range)

❑ Failed plusoptiX photoscreening_____

Eye Doctor's Diagnosis

❑ Amblyopia
❑ Muscle imbalance (type)_____
❑ Refractive Error
❑ Myopia ❑ Hyperopia ❑ Astigmatism
OD sph_____ cyl_____ axis_____
OS sph_____ cyl_____ axis_____
❑ Ptosis
❑ Other
❑ Normal exam

History

❑ New case
❑ Previously diagnosed

Treatment

❑ Glasses prescribed
OD sph_____ cyl_____ axis_____
OS sph_____ cyl_____ axis_____
❑ Patch
❑ Other

Doctor's name (please print)_____

❑ Ophthalmologist ❑ Optometrist ❑ Other: (type) _____

Exam date_____ Phone_____

Please return this form to Prevent Blindness Georgia at the address or fax number listed above, or scan the form and email it to lirby@pbga.org

Consent and Release

I authorize my child's eye doctor to send exam results to Prevent Blindness Georgia.

_____

(Parent's signature) (Date)