Prevent Blindness Georgia®
Our Vision Is Vision™

VISION SCREENING REGISTRATION FORM

School _____ **Date** _____ **Screeners** _____

Contact _____ **Phone** _____ _____

Teacher: Complete these columns before the screening					PlusoptiX		ABC's	Visual Acuity					Remarks/Symptoms	Refer
								Initial			Recheck			
Child's Name	Sex	Birthdate M-D-YY	*Ethnicity	Glasses	Screen	Refer	Fail	R	L	**Re√	R	L		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
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								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		
								20/	20/		20/	20/		

***Ethnicity: African American (AA), Asian (A), Caucasian (C), Hispanic (H), Other (O), Not Specified (NS)**

**For children ages four and five, rescreen then refer, if acuity is worse than 20/40 in one or both eyes or if there is a two-line difference (20/40 & 20/25 or lower, 20/32 & 20/20 or lower, 20/25 & 20/16). Pass line is 20/50 for three-year olds; 20/32 for ages 6+.