Clear Form

DOC
TYPE 2125

**MIAMI-DADE COUNTY PUBLIC SCHOOLS**

| PRINT STUDENT'S NAME *(LAST)* *(FIRST)* *(M.I.)* | DATE (MM/DD/YY) | |
|---|---|---|
| | STUDENT ID. NO. | |

# VISION SCREENING
# M-TEAM REFERRAL REPORT

## VISION SCREENING REPORT

ADDRESS _____
City State Zip Code

TELEPHONE _____ SEX _____ BIRTHDATE _____

SCHOOL _____ GRADE _____ ETHNICITY _____

PARENT/GUARDIAN _____ TEACHER _____

Reason for referral:

_____

_____

_____

_____

| | RIGHT | LEFT | BOTH |
|---|---|---|---|
| Visual acuity without glasses: | | | |
| Visual acuity with present glasses: | | | |
| Visual acuity with prescription recommended: | | | |

Results and Recommendation Summary:

_____

_____

_____

_____

Date of Examination: _____

_____
Signature of Examiner

_____
Title