ST. FRANCIS XAVIER ELEMENTARY

Dear Parent/Guardian of incoming Kindergarteners and Third Graders,

As your child looks forward to the next school year, the Iowa Department of Public Health has issued a new vision screening law that will impact you as a parent. **A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten and again before enrollment in the third grade.**

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment, and no later than six months after the date of child's enrollment into both the Kindergarten and third grade.

Although a comprehensive eye examination by an ophthalmologist or optometrist meets the requirement of vision screening, it is also **highly recommended but not required for Kindergarteners** to have a full comprehensive exam.

Please **RETURN** the completed, signed and dated Certificate of Vision Screening form to the school by the start of the school year. The form is attached to this letter.

Why Is It Important For My Child To Have a Vision Screening?

- **It's the law!** The state of Iowa requires vision screenings for all students entering Kindergarten and **again** when entering 3rd grade.
- Experts estimate that 80% of learning occurs through our vision, so vision exams can help prevent future learning problems.
- Children often do not complain of a vision problem because they have always seen things a certain way and don't realize there is a problem.

Who Can Perform the Vision Screening?

Your doctor	A public or Accredited Nonpublic School
An Eye Doctor	A Community –Based Organization
An Advanced Nurse Practitioner	A free clinic
A Physician's Assistant	A Child Care Center

The Local Public Health Department

Annual vision screenings will be done at school in the fall. **Note: This is not an eye exam.** Iowa Vision Screening forms would be completed then.

If you have any questions contact Jolene Bagge BSN, RN

563-875-7376

IDPH
IOWA Department of PUBLIC HEALTH

Iowa Department of Public Health

CERTIFICATE OF VISION SCREENING

Pursuant with Iowa Code Chapter 641.52

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information vision testing requirements can be accomplished either through a screening (see below) or with a comprehensive eye exam (see other side). Screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*

Date of Vision Screening: _____

Result: (Please check): ☐ Pass or ☐ Fail

Testing method: (Please check) ☐ Vision Screening ☐ Photo Screen ☐ Other: _____

Visual Acuity: (if available) ☐ With Correction ☐ Without Correction

Right Eye_____Left Eye_____ **Text**

Referral to eye health professional: (Please check) ☐ Yes or ☐ No

Business Name/Source of Screening: (please print name of provider office or if provided by school nurse, name of school)

_____

Provider Name: (please print) _____Phone: _____

Signature and Credentials of Provider: _____Date: _____

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RETURN COMPLETED FORM TO CHILD'S SCHOOL.

CONTINUED ON BACK

Iowa Department of Public Health • Bureau of Family Health
FAX 515-725-1760 • 800-383-3826 • www.idph.state.ia.us

IDPH
IOWA Department of PUBLIC HEALTH

Eye Exam Section

Pursuant with Iowa Code Chapter 280.7A

To the Parent or Guardian: The Iowa Optometric Association strongly recommends that to fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. **If you choose to** take your child to an eye care professional for a comprehensive eye exam, this side of the form should be filled out and signed by the eye care professional and returned to the school nurse or teacher by your child.

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health

☐ Normal ☐ Other

Internal Eye Health

☐ Normal ☐ Other

Vision Analysis

R	L		
☐	☐	Normal eyesight	☐ Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐ Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐ Eye focusing difficulty
☐	☐	Astigmatism	☐ Sensitivity to light
☐	☐	Amblyopia	

☐ Other_____

Vision Correction Recommendations

☐ No correction necessary

☐ No change in present prescription

☐ New prescription needed

To be worn for:

☐ Constant wear ☐ Near vision only

☐ Distance vision only ☐ As needed

To the Eye Care Professional: Please sign and date this form after the examination.

Dr. Name (Please Print) _____

Date_____Signature_____