Department of State Health Services

Certificate of Record for Vision Screen and/or Eye Examination

ATTENTION PARENT: The Vision and Hearing Screening Program requires that every child have an eye examination or an approved vision screening test prior to or within 120 days after entry into a Texas public or private preschool or school, licensed child care center, or child care home.

Child's Name _____ Birthdate _____ Age _____

The tests conducted to evaluate your child's vision are screens; they are not diagnostic. This means that if your child fails a screen, it is necessary for him or her to be evaluated by his or her primary care provider to determine whether there is a vision problem. It also means that on some occasions a vision problem may exist that the screens will not identify.

<table>
<tr><td colspan="3">**VISION SCREENER REPORT**</td></tr>
<tr><td colspan="3">DISTANCE ACUITY SCREEN:</td></tr>
<tr><td>1st Screen:
Date _____
With Correction: □ Yes □ No
Chart Used:
Letter □ Rt Eye 20/__ □ Lft Eye 20/ __
"E" □ Rt Eye 20/__ □ Lft Eye 20/ __
HOTV □ Rt Eye 20/__ □ Lft Eye 20/ __
Autom. Screening Device _____
□ PASS □ FAIL</td><td>2nd Screen:
Date _____
With Correction: □ Yes □ No
Chart Used:
Letter □ Rt Eye 20/__ □ Lft Eye 20/ __
"E" □ Rt Eye 20/__ □ Lft Eye 20/ __
HOTV □ Rt Eye 20/__ □ Lft Eye 20/ __</td><td>Comments/Observations:</td></tr>
<tr><td>HIRSCHBERG CORNEAL</td><td colspan="2">COVER AND UNCOVER</td></tr>
<tr><td>Light Reflex Test
□ Light reflection is centered or slightly toward the nose the same distance in each eye.
□ Light reflection is not centered nor slightly toward the nose the same distance in each eye.
□ PASS □ FAIL</td><td>NEAR: 12 to 13 inches
□ No Eye Movement
□ Eye Movement
□ PASS □ FAIL</td><td>FAR: 10 to 20 feet
□ No Eye Movement
□ Eye Movement
□ PASS □ FAIL</td></tr>
<tr><td colspan="3">Referral to a primary care provider due to:</td></tr>
<tr><td>□ Distance Acuity Test
□ Hirschberg Corneal Light Reflex Test
□ Cover and Uncover Test</td><td>□ Observable Signs or Symptoms
_____
_____
(describe)
□ Parent/Doctor Request</td><td>□ Other:
_____
_____
□ UNSCREENABLE</td></tr>
<tr><td>Date of Final Screen:</td><td colspan="2">Name of Screener (please print):</td></tr>
<tr><td colspan="3">Signature of Screener:</td></tr>
</table>

***** WAIVER OF REFERRAL *****

My child _____ is being seen by an eye care specialist,

_____ (doctor's name), for the problem(s) indicated.

Parent's Signature _____ Date _____

Revised 8/2014 M-60