

Iowa Department of Public Health
CERTIFICATE OF VISION SCREENING
RETURN COMPLETED FORM TO CHILD'S SCHOOL

Sac City Elementary Fax 712-662-6245 ~ Wall Lake Elementary Fax 712-664-2607

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 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: _____	
Results (visual acuity):	
Right Eye _____	Left Eye _____
Overall Result (Please select)	Referral to eye health professional (Please select)
Pass or Fail	Yes or No
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>

Screening Provider: _____

Provider Business Name/Source of Screening: (please print) _____

Provider Name: (please print) _____ Phone: _____

Signature and Credentials

of Provider: _____ Date: _____

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 3rd 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 in Kindergarten and no later than six months after the date of the child's enrollment in Kindergarten.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in 3rd grade and no later than six months after the date of the child's enrollment in 3rd grade.

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