Global Village Academy
5720 State Rd. Parma, OH 44134 ♦ Phone: (216) 767-5956 ♦ Fax: (216) 767-5653
globalvillageoh@gmail.com ♦ www.globalvillageacademy.net

VISION SCREENING

Students' Name: _____ Date of Birth: _____

Screening Date: _____

Child wears glasses? ☐ Yes ☐ No

Child tested with glasses? ☐ Yes ☐ No

	Right Eye	Left Eye
NEAR VISUAL ACUITY		
DISTANCE VISUAL ACUITY		

	Pass	Fail
COLOR		
STEREOPSIS		
MUSCLE BALANCE		

CHECK ONE:

[ ] Within Normal Limits
[ ] Needs Recheck
[ ] Needs Referral

Comments: _____

_____

Doctor's Name: _____ Doctor's Signature _____

Address _____

City _____ State _____ ZIP _____

CONTENT AND RELEASE OF INFORMATION

I, _____*(parent/guardian)* of the above named child, hereby authorize the provider completing this report to return this completed form to: ***GLOBAL VILLAGE ACADEMY*** for the specific purpose of notifying the school of any specific vision problems, recommendations and instructions for teachers related to the child's vision problems. This authorization expires upon submission of the completed form to the above named school.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment for services or eligibility for benefits for my child; however, if this form is not submitted to the school, I understand that the school may not have sufficient information to address special vision needs for my child.

_____ _____

(Signature of parent/guardian) *(Date)*