

**Iowa Department of Public Health  
 CERTIFICATE OF VISION SCREENING  
 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 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 one):	Referral to eye health professional (Please select one):
Pass or Fail <input type="radio"/> <input type="radio"/>	Yes or No <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 3<sup>rd</sup> 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 3<sup>rd</sup> grade and no later than six months after the date of the child's enrollment in 3<sup>rd</sup> grade.

**RETURN COMPLETED FORM TO CHILD'S SCHOOL.**