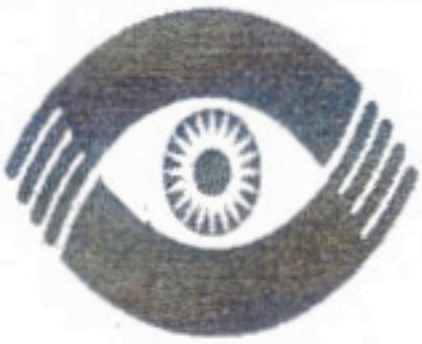
Preschool Vision Screening

A service of



Blind & Vision Rehabilitation Services of Pittsburgh

1800 West Street • Homestead, PA 15120
412-368-4400

Dear Parent/Guardian:

A child repeatedly spills his milk, bumps into walls, and stumbles over toys. Is he clumsy or are these the early warning signs of a vision problem?

To insure that 3 to 6 year olds are seeing as well as they should, **Blind & Vision Rehabilitation Services** offers a *Preschool Vision Screening* program for the children of Allegheny County.

Children are screened for

- Visual acuity
- Muscle balance
- Color discrimination

Screening techniques are

- developed by the National Society to Prevent Blindness
- approved by the Pittsburgh Ophthalmology Society

Why should my child be screened?

- 1 in every 20 children has an undetected vision problem
- The early detection and treatment of vision deficiencies are fundamental to future classroom learning and success

How are screening results reported?

- If you are not contacted, your child passes the vision screening successfully!
- You will be notified of the need for further vision evaluation if your child did not meet the minimum standards for his/her age group.

BVRS is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) regarding confidentiality and privacy.

A REMINDER: This is a screening. It is **not** a complete eye examination. **BVRS** recommends that every child have a complete vision examination by an eye care professional before entering kindergarten.

If you have questions regarding the program, please contact me at _____, or call **Blind & Vision Rehabilitation Services** at 412-368-4400 ext 2209.

Sincerely,

Vision Screening Chairperson

Preschool Vision Screening is free!

Your tax-deductible donation to **'Blind & Vision Rehabilitation Services'** will allow this successful prevention of blindness program to continue. Checks can be attached to this permission slip.

Thank you in advance for your support!

Please return to teacher by _____

PERMISSION FOR VISION SCREENING

Please **PRINT** all information:

School _____

Child's Name_____

Age_____ Birthdate ___/___/___ Sex M☐ F☐

Parent / Guardian
Name _____

Address_____

_____

Phone (H)_____ (W)_____

Has child ever been under the care of an eye specialist?
YES☐ NO☐

Is child currently under the care of an eye specialist?
YES☐ NO☐

Does child wear glasses?
YES☐ NO☐.

If your child wears glasses, please be sure he/she wears them on the screening date.

Parent/Guardian Signature_____

Date_____

Optional: Ethnicity
☐Caucasian ☐African American ☐Hispanic
☐Asian ☐Native American ☐Other

My signature grants permission for the vision screening and the release of results to the facility's professional staff.

For Screener's use:
Color Screening Results: (-)_____ or (red C)_____

Please check any plates missed:
3_____ 4_____ 6_____ 7_____ 8_____

Knows letters _____ Will match letters_____ 7/06