Iowa Department of Public Health
Child Vision Screening

1. Parents or guardians need to make sure their child has a vision screening at least once before starting kindergarten and again before starting 3rd Grade.

2. Kindergarten Screenings: A screening will be counted if it is done no earlier than 1 year before and no later than 6 months after school starts.

3. 3rd Grade Screenings: A screening will be counted if it is done no earlier than 1 year before and no later than 6 months after school starts.

4. The requirement for a child vision screening will count by any of the following:
    a. A vision screening or comprehensive eye exam by an eye doctor (ophthalmologist or optometrist).
    b. A vision screening conducted at a doctor's office, a free clinic, a child care center, a local public health department, a public or accredited nonpublic school, or a community-based organization or by an advanced registered nurse practitioner or physician assistant.
    c. A vision screening done by Prevent Blindness Iowa volunteers or Iowa KidSight and Lion's Club Volunteers.

5. The child vision screening requirement does not apply if the child vision screening conflicts with a parent's or guardian's genuine and sincere religious belief.

6. A child will not be withheld from school because a parent or guardian did not provide proof that the child received a vision screening.

Please direct questions regarding vision screening to:
Iowa Department of Public Health - Bureau of Family Health
321 E 12th Street - Des Moines, IA 50319
FAX 515-725-1760 - Phone 800-383-3826

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):

Pass or Fail

Referral to eye health professional (Please select one):

Yes or No

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.

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health – Bureau of Family Health
321 E 12th Street - Des Moines, IA 50319
FAX 515-725-1760 – Phone 800-383-3826
http://idph.iowa.gov/family-health/child-health/vision-screening

STUDENT VISION CARD

Student First/Last Name _____ Exam Date _____

Student Date of Birth _____/_____/_____ Student Home Zip Code _____

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

The following organizations recommend the use of the Student Vision Card

Iowa Department of Education

IDPH Iowa Department of Public Health

Iowa Optometric Association

Iowa PTA everychild. onevoice.

Prevent Blindness Iowa®

To order more cards call 1-800-444-1772 • www.iowaoptometry.org

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	**L**		
☐	☐	Normal eyesight	☐ Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐ Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐ Eye focusing difficulty
☐	☐	Astigmatism	☐ Sensitivity to light
☐	☐	Amblyopia	

☐ Other _____

Vision Correction Recommendations
☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant wear ☐ Near vision only
☐ Distance vision only ☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) _____

Date_____Signature_____