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 (MIDNYYY):
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

O O

Referral to eye health professional (Please select one):

Yes or No

O O

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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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

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