

**USD 457 Health Services**

**Parent Notification of Hearing/Vision Screening**

**Student:**

**Date:**

Your child's hearing/vision has recently been screened. The results of the screening were:

HEARING: Pass \_\_\_\_\_ Fail \_\_\_\_\_ Will be rescreened by school nurse \_\_\_\_\_

Recommend further evaluation by a doctor \_\_\_\_\_

VISION: Tested with glasses \_\_\_\_\_ Tested without glasses \_\_\_\_\_

Pass \_\_\_\_\_ Watch \_\_\_\_\_ Referral to Optometrist \_\_\_\_\_

Please take referral form to the Doctor

Please feel free to call me with any questions at

Thank you,

School Nurse

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