Screening Date:_____

Student Name:_____

Date of Birth:_____

School Name:_____Grade:_____

Vision Screening Criteria

Kindergarten and younger: Passing is 20/40 | 1st-12th grade: Passing is 20/30

Vision Screening Results

	DISTANCE	NEAR	RANDOM DOT E (circle one)
Right Eye (O.D.)	**20/_____**	**20/____**	**Pass or fail**
Left Eye (O.S.)	**20/_____**	**20/____**	**Pass or fail**

Vision Exam Needed?

- ☐ **YES**
- ☐ **NO**

Vision Exam Results (if applicable)

	SPH	CYL	AXIS	ADD POWER
Right Eye (O.D.)				
Left Eye (O.S.)				

Glasses Prescribed through Kids Vision for Life?

- ☐ **YES**
- ☐ **NO**

Kids Vision for Life St. Louis | 10465 St. Charles Rock Road | St. Ann, Missouri 63074

www.KidsVisionForLifeStLouis.com

PLEASE CALL 1800-475-6320 FOR AN OFFICAL PRESCRIPTION SIGNED BY PRESCRIBING DOCTOR