

SUBJECT: Iowa's Child Vision Screening Law

Dear Parent/Guardian,

Did you know that good eye health can help your child be a better learner at school? Early detection and treatment of a visual impairment will also help them as they play. According to your child's school records, there is not a Child Vision Screening Certificate in their file, which means we need your help to schedule a vision screening as soon as possible.

Since 2015, the State has required students entering kindergarten and 3rd grade to provide proof of a Child Vision Screening Certificate to their school. The goal of the Child Vision Screening Law is to improve the eye health of children and your assistance is appreciated.

About the Child Vision Screening Certificate Form

- The front of the form can be completed by a doctor, a physician's assistant, an advanced registered nurse practitioner, a nurse, a school nurse, or volunteers with Prevent Blindness Iowa or Iowa KidSight and Lion's Club.
- The back of the form must be completed if your child receives a comprehensive eye exam from an eye doctor or ophthalmologist.

What to Do If Your Child Has Already Had a Screening

If your child had a screening and their school records are not updated to show this, provide proof of the screening as soon as possible.

- "Proof of the screening" can include a copy of your child's most recent physical, if a vision screening was provided, or
- A letter from your kid's eye doctor with the results of the vision screening, or
- A copy of the results of an Iowa KidSight/Lion's Club volunteer screening.

Remember, if your child has not had a vision screening, please schedule one as soon as possible.

Sincerely,

Amy Chebuhar MSN, RN
Iowa Department of Health and Human Services
Child and Adolescent Health/EPSTD Nurse Clinician

For help to translate or understand this, call 1-800-464-9484 (TTY: 711).
For help scheduling a vision screening, contact your child's school nurse.
Attachment: Child Vision Screening Certificate Form

Certificate of Vision Screening

Pursuant with Iowa Code Chapter 641.52
Return completed form to child's school

Student Information (please print)

Student's Last Name: _____ Student's First Name: _____

Student Address: _____ Zip Code: _____

Date of Birth (M/D/YYYY): _____ Parent/Guardian Phone Number: _____

Screening Information Vision testing requirements can be accomplished either through a screening (see below) or with a comprehensive eye exam (see other side). 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: _____

Result (Please check): Pass Fail

Testing Method (Please check): Vision Screening Photo Screening Other

Visual Acuity (If available): With Correction Without Correction

Right Eye: _____ Left Eye: _____

Referral to Eye Health Professional (Please check): Yes No

Business Name/Source of Screening (Please print name of provider office; or name of school if provided by the school nurse): _____

Provider Name (please print): _____ Phone: _____

Signature/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 3rd grade and no later than six months after the date of the child's enrollment in Kindergarten and 3rd grade.

Eye Exam Section

Pursuant with Iowa Code Chapter 280.7A

To the Parent or Guardian: The Iowa Optometric Association strongly recommends that 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. **If you choose to** take your child to an eye care professional for a comprehensive eye exam, this side of the form should be filled out and signed by the eye care professional and returned to your child's school nurse or teacher.

Visual Acuity	At Distance		At Near	
<input type="checkbox"/> Without correction	R20/	L20/	R20/	L20/
<input type="checkbox"/> With present correction	R20/	L20/	R20/	L20/
<input type="checkbox"/> With new correction	R20/	L20/	R20/	L20/

External Eye Health		Internal Eye Health	
<input type="checkbox"/> Normal	<input type="checkbox"/> Other	<input type="checkbox"/> Normal	<input type="checkbox"/> Other

Vision Analysis

- | R | L |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Normal Eyesight |
| <input type="checkbox"/> | <input type="checkbox"/> Nearsighted (Myopia) |
| <input type="checkbox"/> | <input type="checkbox"/> Farsighted (Hyperopia) |
| <input type="checkbox"/> | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> | <input type="checkbox"/> Amblyopia |

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- Eye teaming difficulty
 - Crossed eyes (Strabismus)
 - Eye focusing difficulty
 - Sensitivity to light
 - Other

Vision Correction Recommendations

- No correction necessary
- No change in present prescription
- New prescription needed

To be worn for:

- | | |
|---|---|
| <input type="checkbox"/> Constant Wear | <input type="checkbox"/> Near vision only |
| <input type="checkbox"/> Distance vision only | <input type="checkbox"/> As needed |

To the Eye Care Professional: Please sign and date this card after the examination.

Dr. Name (Please Print) _____

Date _____ Signature _____