Agency Program: ________________________________  KIDS Child ID# __________________________

Child’s Legal First Name _____________________  Legal Last Name ___________________________

1. Date Vision Screen Completed: __/__/____  MM/DD/YYYY

2. Screening Location:
   - Child’s Home
   - School District or Agency Building
   - Other ________________________________________________________________

3. Screening Method:
   - Functional Vision Screen
   - Acuity charts/cards
   - Automated (SureSight, etc.)
   - Other ________________________________________________________________

   Left Eye Screening Results:  Right Eye Screening Results
   - Passed  - Passed
   - Failed  - Failed
   - Inconclusive  - Inconclusive

4. As a result of this vision screening, was a recommendation for further assessment or services provided to the parent(s)? (If yes, complete question #5)
   - Yes  - No

5. If yes in question 4, did the family access recommended services for this child? (If no, complete #6)
   - Yes  - No

6. If no in question 5, check all of the following that apply:
   - Family declined further services.
   - Family opts out for religious or other medical reasons.
   - Family lacks access to services (i.e. distance for treatment, lack of transportation, etc.)
   - Additional testing is cost prohibitive.
   - Other ____________________________