



Iowa Department of Public Health
Protecting and Improving the Health of Iowans

Gerd W. Clabaugh, MPA
Director

Kim Reynolds
Governor

Adam Gregg
Lt. Governor

DATE: 2020-2021 School Year

TO: Parents/Guardians of Kindergarten or Third Grade students

FROM: Bureau of Family Health, Iowa Department of Public Health

TOPIC: Iowa's Child Vision Screening Law

Since 2015, the State of Iowa requires students entering kindergarten and third grade to provide proof of a child vision screening to their school. You are receiving this letter because, according to school records, there is not a child vision screening on file for your child.

Please schedule a vision screening for your child as soon as possible. The Certificate of Vision Screening form is attached. The front side can be completed by a doctor, a physician's assistant, an advanced registered nurse practitioner, a nurse, a school nurse, Prevent Blindness Iowa volunteer or Iowa KidSight and Lion's Club volunteers. The back side of the form is to be completed if your child receives a comprehensive eye exam from an eye doctor or ophthalmologist.

If your child has had a vision screening within the last year but has not yet turned in the results of the screening, please ask the person who provided the screening to complete the Certificate of Vision Screening or provide other proof of screening as soon as possible. Once completed, submit the form or proof of screening to the school nurse. "Other proof of screening" could be a copy of the child's most recent physical if a vision screening was provided, a letter from the child's eye doctor with the results of the vision screening, a copy of the results of an Iowa KidSight/Lion's Club volunteer photo screening, etc.

The intent of the child vision screening law is to improve the eye health of Iowa children. The child vision screening can help with early detection and treatment of visual impairment. Having good eye health makes children better learners in school.

Your attention to this matter is appreciated. Thank you!

For more information about the child vision screening law, you may contact the Iowa Department of Public Health at 1-800-383-3826. You may also read more about the program at <https://idph.iowa.gov/family-health/child-health/vision-screening>.



Iowa Department of Public Health

CERTIFICATE OF VISION SCREENING

Pursuant with Iowa Code Chapter 641.52

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

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.*

<p>Date of Vision Screening: _____</p> <p>Result: (Please check): <input type="checkbox"/> Pass or <input type="checkbox"/> Fail</p> <p>Testing method: (Please check) <input type="checkbox"/> Vision Screening <input type="checkbox"/> Photo Screen <input type="checkbox"/> Other: _____</p> <p>Visual Acuity: (if available) <input type="checkbox"/> With Correction <input type="checkbox"/> Without Correction</p> <p>Right Eye _____ Left Eye _____</p> <p>Referral to eye health professional: (Please check) <input type="checkbox"/> Yes or <input type="checkbox"/> No</p>
--

Business Name/Source of Screening: (please print name of provider office or if provided by school nurse, name of school)

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

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

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 the school nurse or teacher by your child.

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

Normal Other

Internal Eye Health

Normal Other

Vision Analysis

R L

- | | | | | |
|--------------------------|--------------------------|------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Normal eyesight | <input type="checkbox"/> | Eye teaming difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | Nearsighted (myopia) | <input type="checkbox"/> | Crossed-eyes (strabismus) |
| <input type="checkbox"/> | <input type="checkbox"/> | Farsighted (hyperopia) | <input type="checkbox"/> | Eye focusing difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | Astigmatism | <input type="checkbox"/> | Sensitivity to light |
| <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia | | |

Other _____

Vision Correction Recommendations

- | | | |
|--|---|---|
| <input type="checkbox"/> No correction necessary | To be worn for: | |
| <input type="checkbox"/> No change in present prescription | <input type="checkbox"/> Constant wear | <input type="checkbox"/> Near vision only |
| <input type="checkbox"/> New prescription needed | <input type="checkbox"/> Distance vision only | <input type="checkbox"/> As needed |

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

Dr. Name (Please Print) _____

Date _____ Signature _____