CLASSROOM LIST FOR VISION SCREENING

School _____ **Date Screened** _____

Teacher _____ **Grade** _____

#	Absent	Rescreen	Forgot Glasses	Name of Student	Pass	Fail	Left	Right	Glasses	Contacts	Comments
1											
2											
3											
4											
5											
6											
7											
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26											
27											
28											
29											
30											

Number of Students Screened _____ Students Referred _____

Referral Sent ☐ SIS ☐