

Dear Parent/Guardian:

The Iowa Department of Health has recently put into effect a law requiring that every student in Kindergarten and third grade have a certificate of vision screening. This will be put into effect for the 2015/16 school year.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment and no later than six months after the date of child's enrollment into both the Kindergarten and third grade.

A vision screening may be conducted by a physician, advanced nurse practitioner, physician assistant, local public health department, public or accredited nonpublic school, community based organization, free clinic, or child care center.

Although a comprehensive eye examination by an ophthalmologist or optometrist meets the requirement of vision screening, it is not a requirement to have a full comprehensive exam. Please have the Certificate of Vision Screening form on the back of this sheet completed and a copy returned to the school by the start of the year. Other vision screening forms are accepted but must include all information on the back form at a minimum.

*For more information on Vision Screening you may visit:*

<https://www.legis.iowa.gov/docs/publications/LGE/85/SF419.pdf>

If you have questions, please do not hesitate to contact me at the school.

Sincerely,

A handwritten signature in black ink that reads "Mary Ries, RN". The signature is written in a cursive, flowing style.

Mary Ries, RN  
Maquoketa Valley Community Schools

**Iowa Department of Public Health  
CERTIFICATE OF VISION SCREENING  
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 screening provider must complete this section *or* parents may attach a copy of vision screening results given to them by a provider.)

<b>Date of Vision Screening:</b> _____	
<b>Results (visual acuity):</b>	
Right Eye _____	Left Eye _____
<b>Overall Result (Please select one):</b>	<b>Referral to eye health professional (Please select one):</b>
Pass or Fail	Yes or No
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>

**Screening Provider:** \_\_\_\_\_

**Provider Business Name/Source of Screening:** (please print) \_\_\_\_\_

**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 3<sup>rd</sup> 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 no later than six months after the date of the child's enrollment in Kindergarten.

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

**RETURN COMPLETED FORM TO CHILD'S SCHOOL.**