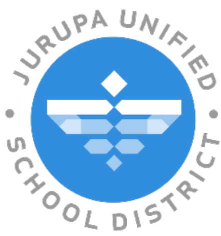

Jurupa Unified School District
Head Start/ State Preschool/ Title 1

Vision Follow-Up Notice

Site/Session: __________

(To be given to Optometrist of your choice. Return within 30 days)
(Para ser entregado al optometrista de su selección. Regreso dentro de los 30 días.)

Dear Provider (Estimado Proveedor),

______________________________ ______________ was identified through the

Name Date of Birth

preschool vision program as needing further vision follow-up and/or vision treatment for the following reasons:

☐ Myopia	☐ Astigmatism	☐ Anisocoria
☐ Hyperopia	☐ Gaze deviation/Asymmetry	☐ Anisometropia

<u>Please provide the following information regarding the status of vision treatment</u>

Select the appropriate box below

☐ Glasses Needed Y N ☐ No Further Treatment needed

☐ Glasses Ordered Y N

☐ Referred to specialist Specialist Name: ____________________________

Office/Provider Name: ____

Provider's Signature or stamp: ___________________________ Exam Date: ______________

<u>Parent Section (If applicable) Sección de padres / si aplica</u>

☐ I am unable to complete treatment for the following reason/ *No se puedo completar el tratamiento por la siguiente razón:* ____

☐ I decline treatment for the following reason/ No quiero el tratamiento por la siguiente razón:

____

(Rev. 6/4/19 TL)