TEXAS Health and Human Services | Texas Department of State Health Services

Certificate of Record for Vision Screen and/or Eye Examination

Child's Name_____Birthdate_____Age_____

DISTANCE ACUITY SCREEN

1st Screen (Date): _____	**2nd Screen (Date):** _____
With Correction: ☐ Yes ☐ No	With Correction: ☐ Yes ☐ No
Chart Used: ☐ Sloan Letter ☐ HOTV	**Chart Used:** ☐ Sloan Letter ☐ HOTV
Result: (R) Eye **20/** (L) Eye **20/**	**Result:** (R) Eye **20/** (L) Eye **20/**

Comments/Observations:

AUTOMATED SCREENING DEVICE

Type of Device: ☐ Photo Screener ☐ Auto-Refractor ☐ Other

Result: ☐ PASS ☐ FAIL

HIRSCHBERG CORNEAL LIGHT REFLEX TEST

☐ Light reflection is centered or slightly toward the nose the same distance in each eye.

☐ Light reflection is not centered nor slightly toward the nose the same distance in each eye.

Result: ☐ PASS ☐ FAIL

COVER AND UNCOVER TEST

NEAR: 12 to 13 inches ☐ No Eye Movement ☐ Eye Movement

FAR: 10 to 20 feet ☐ No Eye Movement ☐ Eye Movement

Result: **Near:** ☐ PASS ☐ FAIL **Far:** ☐ PASS ☐ FAIL

REFERRAL REASON (If applicable)

☐ Distance Acuity Screen
☐ Automated Screening Device
☐ Hirschberg Corneal Light Reflex Test
☐ Cover and Uncover Test
☐ Parent/Doctor Request
☐ Unable to Screen
☐ Other:

Observable Signs or Symptoms (describe):

SCREENING CERTIFICATION

Signature of Screener:

Date:	Print Name of Screener: