

Union County Public Schools  
**Level I - Intervention Process**

**Referral for Vision Screening:**

Date: \_\_\_\_\_

LEVEL I Notification sent by (Staff Member) on (Date)

Referral completed by: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Student's Homeroom Teacher: \_\_\_\_\_

**Vision Screening Results:**

Date: \_\_\_\_\_

**Near Vision:**        (Left) \_\_\_\_\_        (Right) \_\_\_\_\_        (BOTH) \_\_\_\_\_

**Far Vision:**        (Left) \_\_\_\_\_        (Right) \_\_\_\_\_        (BOTH) \_\_\_\_\_

With glasses/corrective lenses

Without glasses/correction

Examiner: \_\_\_\_\_

Follow Up Needed:     NO  
                                  YES

(If YES, Explain): \_\_\_\_\_