CLARINDA
Community School District

423 East Nodaway • P.O. Box 59
Clarinda, Iowa 51632

McKinley Administrative Offices
712-542-5165
FAX 542-3802

High School Office
100 North Cardinal Drive
712-542-5167
FAX 542-4305

Middle School Office
305 East Glenn Miller Drive
712-542-2132
FAX 542-5949

Garfield Elementary Office
910 S. 15th Street
712-542-4510
Fax 542-5949

Vision Screening Requirements for students entering Jr. Kindergarten, Kindergarten and 3rd grade

A new Iowa Law regarding vision screenings will be in effect May, 2015. The purpose of the child vision screening program is to improve the eye health and vision of Iowa's children.

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.

Please have the attached Vision Screening Form completed and returned to the School Nurse at Garfield Elementary. Other vision screening forms are accepted but must include all information on the attached form at a minimum. The parent or guardian of a child enrolled in **kindergarten or 3rd grade** shall ensure that evidence of a child vision screening is submitted to the school district.

The 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 3rd grade.**

Kindergarten Screenings : A screening will be valid if done up to 1 year prior to enrollment and no later than 6 months after enrollment.

3rd Grade: A screening will be valid if done no earlier than 1 year prior to the first day of school and no later than 6 months after the first day of school.

Jennifer Peters RN
School Nurse
712-542-4510
email: jpeters@clarindacsd.org

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.*)

Date of Vision Screening: _____

Results (visual acuity):

Right Eye_____ Left Eye_____

Overall Result (Please select one):

Pass ○ or Fail ○

Referral to eye health professional (Please select one):

Yes ○ or No ○

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

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Bureau of Family Health
FAX 515-242-6013 • 866-383-3826 • www.idph.state.ia.us

3/01/2015