



Mass & RTI Screening Program VISION 2022-2023

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VISION - SCREENING PROGRAM

PURPOSE: To detect those students who may have a vision disorder and refer them for further care.

STUDENTS TO BE SCREENED:

- **MASS SCREENING GRADES:** Parental Permission ***IS NOT Required*** for:

A. Students in Grades 1, 4, 7, and 10

B. *All NEW STUDENTS to Cobb County School District who enter at any point during the year.*

Some schools prefer to screen all students every year. If you choose to do this, please screen the grades listed above first. If your practice is to perform mass screening with all students, parental permission is not required for mass screenings.

- **REFERRAL STUDENTS** – Parent Permission (see forms) ***IS Required*** for:

Students who are not included in the mass screening grade levels (see above) and those who are referred by a teacher, parent or other staff person.

These students should be screened only after permission is received from the child's parents.

Permission forms signed by the parents may be placed in your mailbox throughout the year for referrals from teachers. Any child who is referred must receive a hearing screening within one month of the referral.

The Vision Screening Program is **not** a substitute for routine vision care. It is recommended that all children receive a thorough eye exam by an optometrist or ophthalmologist before beginning Kindergarten. Annual eye exams are recommended for children who wear glasses or contacts. Children who do not wear corrective eye wear should have an eye exam every other year.

SCREENING PROCEDURES USING HOTV:

1. Screen students with the 10-foot HOTV charts.
2. Students who fail the initial screening are re-screened within two weeks
3. Parents of students failing the second screening are mailed a notification letter (V-1).
 - a. Parents may take their child for an exam to a doctor of their choice, an optometrist or ophthalmologist *or*
 - b. Parents may take their child (at no charge) for a refractive **screening** with:

Dr. Ivo Horak, OD
1750 Powder Springs Road, SW
Ste 210
Marietta, Georgia 30064
(770) 436-9123

The optometrist will advise parents whether their child needs a complete eye exam. Cobb County does not pay for full eye exams, medical treatment, or prescription eyewear.

Doctors are also available to provide a full eye exam if the parent so chooses; or parents may schedule an appointment with another eye health provider of their choice. The parent will be responsible for payment, if they choose to schedule a full eye exam for their child, regardless of the eye doctor chosen.

This service is not available to charter school students.

EYE CHART SCREENING: HOTV CHARTS

Testing Capabilities: Screens for distance vision problems.

Testing Limitations: Does not address reading / near-vision problems.

Staff Requirements: Two people (one pointer and one occluder/recorder).

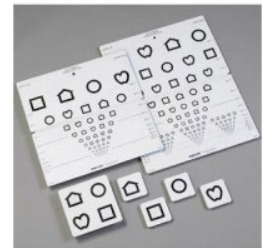
HOTV CHART SCREENING

Equipment Requirements

1. HOTV 10-foot chart (**MUST** be a 10-foot Chart)
2. 3x5 Index cards (occluder–trimming corners off is recommended)
3. Roster Form (V-4)
4. Masking Tape
5. Measuring Tape 10'
6. Pointer or Pencil
7. Cover Sheet
8. Paper Clips
9. Two paper Foot Prints (optional)



NOTE: LEA SYMBOLS CHARTS may be used with preschool or hard-to-test students (see below)



HOTV Testing Guidelines

A. Preparation for the screening:

- a. Hang the HOTV chart at the average eye level of the age group being screened. The HOTV chart is appropriate for school-aged students.
- b. Screen using the:
 - 20/40 (10/20) line for KG and 1st Graders; and the
 - 20/30 (10/16) line for grades 2 thru 12.
- c. You may use paper clips and heavy paper to cover the lines not being tested.
- d. Place a line of tape or the heel of the paper footprints at a distance of 10 feet from the chart.
- e. For all students, make sure that they are able to identify the four letters: H, O, T, and V. (ie: Does the student know the names of those four letters?) You may use the top line on the chart to make this determination. If the child is not able to name the letters, you may use response cards (matching) or use an LEA Symbols chart.

B. Responsibilities of the screeners (pointers and occluder/recorders):

- a. One staff member should stand next to the chart and point to the symbol or letter that the student should identify.
- b. One staff member should verify the symbol/letter is identified correctly and record a pass or fail response.

C. Initial screening procedures:

- a. The student's heels are placed on the 10 foot line.
- b. Both eyes should be open at all times.
- c. If glasses or contact lenses are used to see at a distance then they should be worn during the screening.
 - i. If the student fails the screening with the glasses on, then the glasses should be removed and the eyes should be retested.
 - ii. If the student correctly identifies the symbols/letters without the glasses on then the glasses may be for reading.
- d. Use the occluder/index card to cover the eye not being tested. (It's best practice to trim the cards/round the corners of the cards, to avoid having sharp corners near students' eyes.)
- e. Never press on the eye with the index card as this may distort the vision.
- f. The right eye should always be tested first and then the left eye second.
- g. Point to the letters on the line being tested in random order.
- h. **To receive credit for a line, the child must correctly identify 3 of the 5 letters on the line.**
- i. Record the results of the screening as pass or fail for the right and then the left eye.
 - i. 90% of the students should pass the screening.
 - ii. Nearsightedness can tend to begin around age 9 (fourth grade), therefore you may have a slightly higher failure rate at that age.
- j. If a student's eye turns up, down, in or out, then they fail the screening.
- k. **IF THE STUDENT PASSES THE SCREENING FOR ONE EYE AND FAILS THE SCREENING FOR THE OTHER EYE, THE STUDENT FAILS THE ENTIRE SCREENING.**

Record the results of the screening as pass or fail for the right and then the left eye.

Vision Screening Tips for Students with Additional Needs

Special Concerns for use of LEA Chart

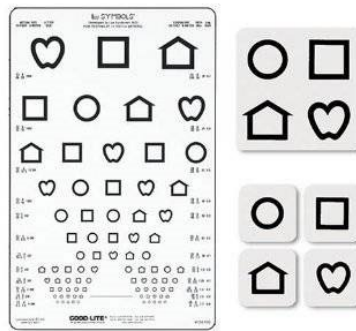
Practice *matching* or *naming* the symbols for a few minutes before officially screening the student. Using the symbols at the top of the chart to practice or the matching cards to confirm the student can perform the task.

Materials:

LEA Symbols Chart

LEA Symbol Cards

Tape Measure



- If the student can verbally name the symbols they can stand at a distance of 10 feet from the chart. A piece of tape can be used as a marker for the student to place their heels upon to complete the task.
- If a student is identifying the symbols using the LEA Symbol cards, then a desk/table can be used to place the cards upon. The student can either sit or stand at the desk/table. The student can also sit on the floor if they are more comfortable there.
- To determine the distance from the student, using the table, measure from the student's temple to the chart.
- When measuring the distance you could ask the student to assist holding the tape measure as you measure or ask the adult assisting in the screener.
- The chart should be placed at eye level from where the student is sitting/standing.

Ideal Testing Environment:

- Find a quiet familiar place to complete the vision screener. Minimize distractions if possible.
- Adequate overhead lighting is required.
- Involve a familiar adult when testing (teacher, paraprofessional, etc.)

Alternative Ways for the Student to Respond:

- Name approximation is acceptable as long as the response is consistent. The vision screener is a test of the student's vision and not a test of their cognitive abilities. Examples: apple – heart, circle – oval, house – triangle, etc.
- The student can point to a symbol on the single LEA Symbol card with all four shapes or the LEA individual symbol cards (4 total). *See image of chart.

Additional Suggestions for a Successful Screener:

- Use rewards for completing the task. Food may be used as a motivator but ask the teacher prior to the screener what foods are acceptable (confirm there are no allergies). Stickers may also be used.
- During the screener, cover the lines above and below the line you are screening to eliminate any confusion for the student.
- Test all five symbols on the line. Remember the student only has to correctly identify 3 out of 5 symbols in order to pass the vision screener.

Record the results of the screening as pass or fail for the right and then the left eye.

FOLLOW-UP SCREENING PROCEDURES USING HOVT CHARTS

- A. Any student who fails the initial screening should be re-screened, using the identical screening procedure, within 2 weeks**
- a. Any student who fails the second screening will have a parent notification letter (V-2) mailed to their parent or guardian.
 - b. The screening recording form (V-1) and a copy of the parent notification letter (V-2) must be kept on file in the school office for one year.
- B. Screening authorizations:**
- a. Parent permission for students screened in the mass screenings (grades 1, 4, 7 and 10) is not required.
 - b. Parent permission is required for students not falling into a category listed in “a”, above.
 - c. If a student is requested to be screened by a teacher, the school or a parent then a permission form (V-4) must be completed.
 - i. The referring individual must complete form (V-4) and have it signed by the parent or guardian.
 - ii. A student who is referred must be screened within one month of the referral.
- C. Record keeping:**
- a. If the response to the parent notification letter (V-2) is not received within 30 days, mail out the parent notification follow-up letter (V-3).
 - b. All students new to Cobb County Schools must have a completed Certificate of Ear, Eye, Dental and Nutrition Examination (Form 3300) on file in the school office, dated no earlier than August 1, 2019.
You are not required to complete a certificate for each student being screened.
 - c. If a student chooses to see one of the eye doctors listed above (page 4), the eye doctor will notify the school via letter (CCS-3/5), regarding the results.
 - i. Upon receipt of the letter (CCS-3/5), a note should be made on the list of the screening failures that the student has had a vision screening or exam performed by the vision consultant.
- D. Confidentiality:** Do not discuss the results of the screening with anyone other than the student, parents/guardians of the student, school officials or the student’s teachers.

MASS SCREENING PROCEDURES USING SPOT:

This vision screening is conducted by Lions Club. Please contact Mr. Ed Ressler at edward8744@att.net or call 404-444-2064 to schedule.

The school still needs to have at least TWO staff members trained for RTI and direct requests.

A. SPOT testing information

1. Lions Club is a volunteer organization that does not charge the school or county to provide vision mass screening for CCSD.
2. **The school MUST provide staff or volunteers to organize who needs to be screened and to manage the flow of students.** The Lions may not be able to return if they cannot finish because students were not made available.
3. No second screening is needed to follow-up failed results with the SPOT screening.
4. Lions Club can help provide eye exams and glasses for students identified with vision issues who qualify for financial assistance.
5. Lions will screen students recommended by staff (with advance parental permission, noted below) and staff members (time permitting).

B. Screening authorizations:

1. Parent permission for students screened in the mass screenings (grades 1, 4, 7 and 10) is not required.
2. Parent permission is required for students not falling into a category listed in "1", above.
3. If a student is requested to be screened by a teacher, the school or a parent then a permission form (V-4) must be completed.
 - i. The referring individual must complete form (V-4) and have it signed by the parent or guardian.
 - ii. A student who is referred must be screened within one month of the referral.

C. Record keeping:

1. If the response to the parent notification letter (V-2) is not received within 30 days, mail out the parent notification follow-up letter (V-3).
2. All students new to Cobb County Schools must have a completed Certificate of Ear, Eye, Dental and Nutrition Examination (Form 3300) on file in the school office, dated no earlier than August 1, 2019.
You are not required to complete a certificate for each student being screened.
3. If a student chooses to see one of the eye doctors listed above, the eye doctor will notify the school via letter (CCS-3/5), regarding the results.
 - i. Upon receipt of the letter (CCS-3/5), a note should be made on the list of the screening failures that the student has had a vision screening or exam performed by the vision consultant.

Confidentiality: Do not discuss the results of the screening with anyone other than the student, parents/guardians of the student, school officials or the student's teachers.

Intentionally Black Page
Forms below

ATTACH YOUR SCHOOL LETTERHEAD HERE BEFORE PHOTO-COPYING

STUDENT'S NAME: _____ DATE: _____

Dear Parents:

This letter is to inform you about the VISION SCREENING PROGRAM conducted for our students. The school screening is not a substitute for a complete vision examination, but rather a way to identify students with a visual problem who are in need of further care. Your child was not able to pass the mass vision screening conducted at school. Failing the screening does not necessarily indicate that a problem exists, only that your child was not able to pass this particular screening.

We recommend that your child receive a complete vision examination by an eye doctor. Please take this form with you to your eye doctor when you have your child's eyes examined.

If you wish to verify the need for an eye examination, the district will provide a professional **re-screening** to you at no charge. This is a more thorough screening, performed by an eye doctor, but is not a full eye exam.

To schedule a professional **screening**, you may contact:

Dr. Ivo Horak, OD,
1750 Powder Springs Road, SW
Ste 210
Marietta, Georgia 30064
(770) 436-9123

Dr. Horak accepts Medicaid and many other vision and health plans, and is fluent in Spanish.

Please let the secretary at the eye doctor's office know that you would like to schedule a "Cobb County School Screening". This is not a complete eye examination – It is re-screening to determine if a complete eye exam is needed.

If a complete eye examination is recommended, you may schedule a time to have your child seen by either Dr. Horak, or any eye doctor of your choice. The cost of the full eye examination, treatments, or recommendations is the responsibility of the parents. If you have health insurance, you may wish to check with your plan to see if they cover the cost of an eye exam and/or prescription eyewear.

A child should have an eye exam before kindergarten. If a child wears glasses or contacts an eye exam is recommended each year. A child without prescription eyewear should have an eye exam every other year. *The eye doctor will be able to see additional family members, by appointment.*

Thank you very much.

Student was tested with eye chart

HOTV Chart LEA Symbols Chart

	Right Eye	Left Eye
Distance Vision	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

 Student was tested with SPOT Vision Screener:

	Right Eye	Left Eye
Distance Vision Test	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

Student was tested with SPOT vision screener.

AFTER EYE DOCTOR APPOINTMENT: FINAL SCREENING RESULTS:

PARENTS: PLEASE DETACH THIS FORM AND RETURN IT TO YOUR CHILD'S TEACHER OR THE SCHOOL SECRETARY.

- My child had a re-screening with Dr. _____ on the following date: _____.
- My child had an eye examination on the following date: _____.
 Prescription glasses or contacts were recommended.
 No glasses or contacts were recommended.

CHILD'S NAME: _____ PARENT'S NAME: _____
 HOME PHONE NUMBER: _____ WORK/CELL NUMBER: _____

ATTACH YOUR SCHOOL LETTERHEAD HERE BEFORE PHOTO-COPYING

NOMBRE DEL ESTUDIANTE: _____ FECHA: _____

Apreciados Padres de Familia:

Esta carta es para informarle acerca del PROGRAMA DE CHEQUEO DE LA VISTA para nuestros estudiantes. La prueba realizada en la escuela no reemplaza el examen completo de la visión, pero sirve para identificar a los estudiantes que puedan tener problemas visuales y que necesitan de cuidado. Su hijo/a no paso la prueba de visión realizada en la escuela. El no haber pasado la prueba, no significa necesariamente que haya un problema de visión, solo que su hijo/a no paso este examen en particular. **Le recomendamos llevar a su hijo/a a una evaluación completa de la visión, por parte de un doctor especializado en visión. Por favor entréguele este formulario al doctor, el día de la cita.**

Si usted desea verificar la necesidad de un examen visual, el distrito le ofrece una **evaluación** refractiva, sin ningún costo. Esta es una evaluación más minuciosa, realizada por un Optómetra, pero no es un examen completo.

Para programar una cita de **evaluación**, comuníquese con:

Dr. Ivo Horak, OD,
1750 Powder Springs Road, SW
Ste 210
Marietta, Georgia 30064
(770) 436-9123

Dr. Horak acepta Medicaid y otros planes de salud y visión y habla español.

Por favor dígame a la secretaria de la oficina del doctor, que usted quiere programar una “cita de evaluación de Cobb County School”. Este no es un examen completo de la visión, es más una reevaluación para determinar si se necesita un examen completo.

Si le recomiendan un examen complete de la visión, usted debe programar una cita para que su hijo/a sea visto por Dr. Horak, Dr. Davison, Dr. Schirack o Dr. Mobley – o cualquier doctor que usted escoja. El costo del examen completo de la visión, de los tratamientos o de las recomendaciones, es responsabilidad de los padres. Si tiene un seguro de salud, debe chequear su plan para ver si cubre el costo del examen y/o la prescripción recomendada.

Antes de entrar al Kínder, se le debe hacer un examen de los ojos al niño/a. Si el niño/a usa gafas o lentes de contacto, se recomienda que tenga un examen de la vista todos los años y si no usa ninguna prescripción, entonces debe hacerse revisar cada 2 años. *El doctor de los ojos puede atender otros miembros de la familia, haciendo una cita.*

Muchas gracias.

Student was tested with eye chart

HOTV Chart LEA Symbols Chart

	Right Eye	Left Eye
Distance Vision	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
<input type="checkbox"/> Student was tested with SPOT vision screener.		

Student was tested with SPOT Vision Screener:

	Right Eye	Left Eye
Distance Vision Test	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

PARA USO EXCLUSIVO DEL DOCTOR: RESULTADOS FINALES DE LA EVALUACION:

PADRES: POR FAVOR DESPRENDA ESTE FORMULARIO Y DEVUELVALO AL MAESTRO DE SU HIJO/A O A LA SECRETARIA DE LA ESCUELA.

- **Mi hijo/a tuvo una reevaluación con Dr. _____ en esta fecha: _____.**
- **Mi hijo/a tuvo un examen de la visión en esta fecha: _____.**
 _____ **Se recomendaron gafas o lentes de contacto.**
 _____ **No se recomendaron gafas o lentes de contacto.**

NOMBRE DEL NIÑO/A: _____ **NOMBRE DE LOS PADRES:** _____
TELEFONO DE LA CASA: _____ **TELEFONO TRABAJO/CELULAR:** _____

FOLLOW-UP VISION SCREENING LETTER V-3

ATTACH SCHOOL LETTERHEAD BEFORE PHOTO-COPYING

STUDENT'S NAME _____ DATE _____

Dear Parent:

We recently sent you a letter indicating that your child was unable to pass the school vision screening and that either a full eye examination or a more thorough refractive screening was recommended. In order to measure the effectiveness of our vision screening program, we are asking you to CHECK ALL THE APPROPRIATE BOXES BELOW and RETURN THIS FORM TO THE SCHOOL, either by sending it to your child's teacher, or by mailing it to the school secretary at the above address.

- My child had an eye exam on the following date _____.
- No glasses were recommended.
- Prescription glasses or contact lenses were prescribed.
- My child had an eye exam within the last six months and no vision problems were found, therefore I did not take my child for another eye exam.
- I cannot afford an eye exam for my child, please call me so that other arrangements can be made.
- My child had a further screening with one of the optometric consultants for Cobb County School District. Name of optometrist: _____
- My child passed the screening and no further examination was necessary.
- My child was unable to pass the screening and a full eye exam was recommended.

PARENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Parent Name: _____

Home Phone: _____ Work Phone: _____

Thank you for your assistance,

Sincerely, _____

NOTE: If you wish to verify the need for an eye examination, the district will provide a professional **re-screening** to you at no charge. This is a more thorough screening, performed by an eye doctor, but is not a full eye exam.

To schedule a professional **re-screening**, you may contact:

Dr. Ivo Horak, OD,
1750 Powder Springs Road, SW
Ste 210
Marietta, Georgia 30064
(770) 436-9123

Dr. Horak accepts Medicaid and many other vision and health plans, and is fluent in Spanish.

Please let the secretary at the eye doctor's office know that you would like to schedule a "Cobb County School Screening". This is not a complete eye examination, but rather a re-screening to determine if a complete eye exam is needed. If a complete eye examination is recommended, you may schedule a time to have your child seen by either Dr. Horak, Dr. Davison, Dr. Schirack, or Dr. Mobley - or any eye doctor of your choice. The cost of the full eye examination, treatments, or recommendations is the responsibility of the parents. If you have health insurance, you may wish to check with your plan to see if they cover the cost of an eye exam and/or prescription eyewear

FOLLOW-UP VISION SCREENING LETTER VS-3

ATTACH SCHOOL LETTERHEAD BEFORE PHOTO-COPYING

NOMBRE DEL ESTUDIANTE _____ FECHA _____

Apreciados Padres de Familia:

Recientemente le enviamos una carta en donde le informábamos que su hijo/a no había pasado la evaluación de la vista en la escuela y que se le recomendaba un examen completo de la visión o una evaluación refractiva. Para poder medir el nivel de efectividad de nuestro programa de evaluación de la vista, le pedimos que **MARQUE LAS RESPUESTAS APROPIADAS y QUE DEVUELVA ESTE FORMULARIO A LA ESCUELA**, enviándolo al maestro de su hijo/a o enviándolo por correo a la secretaria de la escuela.

Mi hijo/a tuvo un examen de la visión en esta fecha _____.

No le recomendaron gafas

Le prescribieron gafas o lentes de contacto.

Mi hijo/a tuvo un examen de la visión en los últimos seis meses y no le encontraron problemas de la vista, por lo tanto no he llevado a mi hijo/a a otro examen de la visión.

No puedo pagar por un examen de la vista para mi hijo/a, por favor llámeme para buscar una solución.

Mi hijo/a tuvo una cita de seguimiento con uno de los optómetras del Cobb County School District. El nombre del Optómetra es: _____

Mi hijo/a paso la evaluación y no fue necesario un seguimiento.

Mi hijo/a no paso la evaluación y se recomendó una evaluación complete de la visión.

PADRES, POR FAVOR COMPLETEN LA SIGUIENTE INFORMACION:

Nombre de los Padres: _____

Teléfono de la Casa: _____ Teléfono del Trabajo: _____

Gracias por su ayuda,

Atentamente, _____

NOTA: Si desea verificar la necesidad de un examen completo, el distrito le ofrece una **reevaluación** profesional, sin ningún costo. Este es un examen más minucioso, realizado por un doctor de la vista, pero no es un examen completo.

Para hacer una cita de **reevaluación**, comuníquese con:

Dr. Ivo Horak, OD,
1750 Powder Springs Road, SW
Ste 210
Marietta, Georgia 30064
(770) 436-9123

Dr. Horak acepta Medicaid y otros planes de salud y visión y habla español.

Por favor dígame a la secretaria de la oficina del doctor, que usted quiere programar una "cita de evaluación del Cobb Conty School". Este no es un examen completo de la visión, es más una reevaluación para determinar si se necesita un examen completo.

Si le recomiendan un examen complete de la visión, usted debe programar una cita para que su hijo/a sea visto por Dr. Horak, Dr. Davison, o Dr. Schirack – o cualquier doctor que usted escoja. El costo del examen completo de la visión, de los tratamientos o de las recomendaciones, es responsabilidad de los padres. Si tiene un seguro de salud, debe chequear su plan para ver si cubre el costo del examen y/o la prescripción recomendada

Parent/Guardian Authorization Release for Screening
(ATTACH SCHOOL LETTERHEAD HERE BEFORE PHOTO-COPYING)

STUDENT'S NAME: _____ DATE: _____

Dear Parents:

The following letter is to inform you about the VISION SCREENING PROGRAM conducted for our students. We want you to understand that this is not a substitute for a complete vision examination, but rather serves as a method for us to screen our students and suggest further care for those who may have problems with their vision.

We are requesting permission to perform a vision screening with your child at your child's school. If your child is able to pass this screening, no further information will be sent to you. However, if your child is unable to pass the vision screening, a letter will be sent to you in approximately three weeks advising you of the results and recommendations.

Thank you for your assistance.

Sincerely,

I hereby grant my permission for a vision screening of my child by representatives of Cobb County School District.

Parent or Guardian Signature: _____ Date: _____

Please return to your child's teacher.

PERMISSION FOR REFERRED STUDENTS- SPANISH
(ATTACH SCHOOL LETTERHEAD HERE BEFORE PHOTO-COPYING)

Nombre del estudiante

Fecha

Estimados padres:

La presente carta es para informarles sobre el PROGRAMA DE EXAMEN DE LA VISTA dirigido hacia nuestros estudiantes. Es importante que ustedes entiendan que este examen no sustituye un examen visual completo, sino que sirve como instrumento para examinar a los estudiantes y sugerir medidas de seguimiento médico a aquellos que posiblemente tengan problemas visuales.

Le queremos pedir permiso para hacerle un examen de la vista a su hijo(a), el cual será efectuado por voluntarios del PTA (Asociación de padres y maestros) y/o maestros de la escuela de su hijo(a). Si su hijo(a) pasa este examen, no será necesario enviarle información adicional. Sin embargo, si su hijo(a) no pasa este examen de la vista, le enviaremos una carta en aproximadamente tres semanas informándole de los resultados y recomendaciones.

Gracias por su ayuda.

Atentamente,

Por este medio doy permiso para lo siguiente:

Un examen de la vista a mi hijo(a), efectuado por los representantes de las Escuelas Públicas del Condado de Cobb.

Firma del padre, madre o guardián

Fecha

Por favor devuelva esta carta al PTA de la escuela de su hijo(a).

(VS-4)

COBB COUNTY PUBLIC SCHOOLS

**HEARING AND VISION SCREENING
Reporting Form Totals**

TO: Dr. Cindy Fleming, Audiologist (Kennesaw Warehouse)

FROM: _____ DATE: _____

This form is to be completed and sent to Cindy Fleming (audiology@cobbk12.org) by **January 09, 2023**.

HEARING: Total number screened: _____

Total number failures for first screening: _____

Total number failures for second screening: _____

VISION:

<i>Lions Club vision screening</i>	<i>School Completed Vision Screening</i>
Total number screened: _____	Total number screened: _____
Total number referred: _____	Total failures 1 st screen: _____
	Total refers 2 nd screen: _____

Were all failure letters sent home: YES or NO

Signature

Printed name

SCHOOL

THANK YOU

Form A200

**CONTACT INFORMATION FOR
SCREENING OPTOMETRIST**

Cobb County School District has an agreement with a local optometrist to perform re-screenings at no charge to students who have failed the Cobb County School District vision screening. This is not an eye exam, it is only a screening to determine if an eye exam is recommended. This service is not available to charter school students. The Cobb County School District will not pay for eye exams, follow-up care, or corrective lenses.

Dr. Ivo Horak, OD
1750 Powder Springs Road, SW
Ste 210
Marietta, Georgia 30064
(770) 436-9123

EYE EXAMINATION RESOURCE GUIDE

Parents may also choose to have a full eye examination for their child.. **Cobb County School System does not pay for full eye examinations or follow-up treatment for children who have failed the school screening.** Parents can seek care for their child by paying for it privately or by using vision insurance if they have coverage.

Lions Club

- a. *The Lions Club has a program to fill a prescription for glasses if a child has already had an eye examination and has a valid prescription for glasses. The patient cost for the glasses is about \$39.00. Contact the Lions Club at (404) 325-3630.*
- b. *The Lions Club will also provide for a complete eye exam and two pair of glasses for students that an eye exam is recommended and who qualify.*

1. Eye doctor to consider:

Dr. Ivo Horak, OD,
1750 Powder Springs Road, SW
Ste 210
Marietta, Georgia 30064
(770) 436-9123

Dr. Horak accepts Medicaid and many other vision and health plans, and is fluent in Spanish.

SPECIAL EDUCATION and VISION - INFORMATION FOR TEACHERS

Students who are normally-sighted, and who are not served via special education are students, who have no vision concerns or whose vision can be corrected to 20/30 or better, and who are enrolled in general education classes. The standard vision screening and referral procedures are implemented for these students.

Students who are normally-sighted, and who served via special education are students who have no vision concerns or whose vision can be corrected to 20/30 or better, and who are enrolled in a special education program.

Students must pass a vision screening before being evaluated for special education eligibility or being given a psychological evaluation. This includes a distance vision and/or a near vision screening (near vision procedures are not included in this manual). For students with adequate comprehension abilities who are unable to pass the vision screening, follow the guidelines as outlined above for general education students.

Some students may be unable to understand, respond to, or comprehend the vision screening instructions. If little or no response to the vision screening is received, then the student does not need to be re-screened at school. The referral letter (V-1) and a blank copy of the Georgia Eye Report (next page) should be sent to the parent indicating that their child was unable to participate in the standard screening procedures. A complete vision examination is recommended. Parents may select an eye doctor of their choice, an optometrist or ophthalmologist, or one of the Cobb County School Optometric Consultants. The cost of the full eye exam is the responsibility of the parent.

If the parent states that the student has had a vision examination within the past year, or that the parent will be taking their child for an eye examination, the teacher should request that the parent have the eye doctor complete the *Georgia Eye Report* (next page).

Using this form will encourage the reporting and sharing of needed information with the teachers, educational consultants and the school. Let the parent know that any additional educational and psychological testing will be delayed until the vision results are obtained.

Visually impaired students are students with vision that cannot be corrected to 20/70 or better in at least one eye with glasses or contact lenses. These students may already be served by the Vision Impaired Program, or may need to be referred. Reasons for vision loss are generally due to an eye injury or eye disease. Students who are visually impaired will not be able to respond appropriately to HOTV or SPOT Vision Screener. For these students an additional vision screening will not yield further useful information. Contact the Vision Supervisor for the Cobb School District (Dr. Bobbie Ealy at 770-426-3497) to discuss further testing.

For further information or clarification on specific vision referral procedures, please contact Dr. Bobbie Ealy, Special Education (770-426-3497); or email Bobbie.Ealy@cobbk12.org

Georgia Instructional Materials Center

Eye Report for Vision Services & APH Registration



Section 1: Demographics						
Student Name: _____			DOB: _____			
School System: _____			Date of Current Eye Exam: _____			
Section 2: Eligibility for Vision Services and Federal Quota Fund Registration (mark all that apply)						
<input type="checkbox"/> Visually Impaired (VI) 20/70 or less in the better eye after correction or there is a limited visual field that could adversely affect educational progress.						
<input type="checkbox"/> Meets the Definition of Blindness (MDB) 20/200 or less in the better eye after correction or visual field no greater than 20 degrees.						
<input type="checkbox"/> Meets the Definition of Blindness (MDB) Immutable Condition (bilateral enucleations, etc)						
<input type="checkbox"/> Functions at the Definition of Blindness (FDB) Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment.						
Section 3: Visual Diagnosis & Prognosis						
Diagnosis: _____						
Prognosis: <input type="checkbox"/> stable <input type="checkbox"/> unstable <input type="checkbox"/> capable of improving <input type="checkbox"/> uncertain						
Section 4: Acuities & Visual Fields <i>If unable to obtain Snellen Acuity, consider the FDB criteria</i>						
	Distance Acuity (ft.)			Near Acuity (in.)		
	O.D.	O.S.	O.U.	O.D.	O.S.	O.U.
Corrected						
Without Correction						
Counts Fingers: <input type="checkbox"/> O.D <input type="checkbox"/> O.S Hand Movement: <input type="checkbox"/> O.D <input type="checkbox"/> O.S Object Perception: <input type="checkbox"/> O.D <input type="checkbox"/> O.S Light Perception: <input type="checkbox"/> O.D <input type="checkbox"/> O.S Is there a field limitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____ <i>Please attach diagram of visual fields if tested.</i>						
Section 5: Prescription <i>Complete if glasses and/or contact lenses prescription issued</i>						
OD: sphere _____ Cylinder _____ Axis _____						
OS: sphere _____ Cylinder _____ Axis _____						
Glasses: <input type="checkbox"/> To be worn constantly <input type="checkbox"/> for close work only <input type="checkbox"/> for distance only <input type="checkbox"/> for protection						
Section 6: Surgery, medications:						
Section 7: Recommendations (lighting levels, restrictions, attach additional pages if necessary)						
Section 8: Authorizations						
Doctor's Name Printed: _____						
Name of Practice: _____						
Doctor's Signature: _____						MD or OD (circle one)
Parent/guardian Signature: _____						Date: _____
<i>I authorize the above person to release this information for educational purposes.</i>						