State of Wisconsin
Department of Regulation and Licensing

KINDERGARTEN EYE HEALTH EXAMINATION REPORT

Student's Name _____ Birth Date _____ Sex _____

Parent or Guardian _____ Phone _____

Address _____ County _____

School/Kindergarten _____ City _____

Date entering Kindergarten _____

The State of Wisconsin encourages parents of Kindergartners to arrange for their child's eyes to be examined by an optometrist or evaluated by a physician by December 31 of the child's first year in school. An examination or evaluation should include, at a minimum, the elements listed below. (By checking the box, the examining doctor is indicating that the element checked was performed.)

- ☐ Brief history (general health and eye health) of the child, including family history
- ☐ General external observation of the child's eyes and surrounding structures
- ☐ Ophthalmoscopic examination through an undilated pupil
- ☐ Gross measurement of peripheral vision
- ☐ Evaluation of eye coordination and function (alignment and motility)
- ☐ Visual acuity for each eye (separately)

Findings:

As a result of this examination, follow-up care for the child is recommended: ☐ Yes ☐ No

Date of examination:

_____

Doctor/Physician Signature:

_____

Print or stamp:
Doctor/Physician Name
Address
Phone

IMPORTANT NOTICE TO PARENTS

This examination is not required by law. Disclosure of the information noted above is necessary to comply with the statutory purpose as outlined in s. 118.135, Wis. Stats.

Disclosure of this information is voluntary and there is no penalty for non-compliance.

You are encouraged to provide a copy of this form to the school and keep a copy for your record.

Consent of parent or guardian: I agree to release the above information on my child to appropriate school authorities and consent to my child obtaining an eye examination.

Signature _____

Date _____

#2540 (2/02)
s. 118.135, Stats.

State of Wisconsin
Department of Regulation and Licensing

INFORME DEL EXAMEN DE SALUD DE LOS OJOS PARA KINDERGARTEN (KINDERGARTEN EYE HEALTH EXAMINATION REPORT)

Nombre del Alumno_____ Fecha de Nacimiento_____ Sexo _____

Padre/Madre o Guardián _____Numero de Teléfono _____

Dirección _____

Ciudad_____Condado_____

Escuela/Kindergarten _____Fecha de Ingreso_____

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To be completed by the examining doctor

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- ☐ Visual acuity for each eye (separately)

Findings:

As a result of this examination, follow-up care for the child is recommended: ☐ Yes ☐ No

Date of examination:

_____

Doctor/Physician Signature:

_____

Print or stamp:
Doctor/Physician Name
Address
Phone

AVISO IMPORTANTE A LOS PADRES DE FAMILIA

Este examen no es requerido por ley. La información anotada abajo es necesaria para cumplir con los requisitos establecidos en la sección 118.135 de los estatutos del Estado de Wisconsin.

El proporcionar esta información es voluntario y no hay niguna sanción si usted no la proporciona. Le sugerimos que entregue una copia de esta forma a la escuela y que usted se quede con otra copia.

Consentimento de padre/madre o guardián:
Estoy de acuerdo en proporcionar la información sobre mi hijo/a a las autoridades apropiadas de la escuela y estoy de acuerdo que mi hijo/a reciba el examen de los ojos.

Firma_____

Fecha_____

#2540 - Spanish (6/02)
s. 118.135, Stats.