2017-2018
FREE Kindergarten Vision Screening

The following Optometrists have volunteered to provide **FREE** kindergarten screenings in their offices. I encourage you all to take advantage of this rare FREE preventative health opportunity offered to families in the Allen County Non Public School Association (ACNPSA).

It is necessary to follow the guidelines below in order to ensure a free, professional vision screening.

1. Call one of the following offices and identify yourself and the non-public school your child will be attending.
2. **CALL for an appointment no later than JULY 1** and tell them that your appointment is for kindergarten screening.
3. Be sure to take this kindergarten vision screening report form with you for the optometrist to complete.

Dr. Thomas Baker 749-0407
1318 Minnich Rd. New Haven, IN

Dr. Aileen Heaston 489-3996
10301 Dawson's Creek Blvd. Suite A Ft. Wayne, IN

Dr. Troy Hockemeyer 493-1505
10848 Rose Ave, Suite 1 New Haven, IN

Dr. Myra Weber 486-8833
6110 Maplecrest Rd. Ft Wayne, IN

Dr. Thomas Zachman 432-1231
7625 W. Jefferson Blvd. Ft Wayne, IN

***We are most appreciative to the above optometrists for their services to the Allen County Non-Public Schools! At the time of your child's appointment, **PLEASE** give them a word of thanks for taking time out of their practice to give back to our community.

(rev ACNPSA 1/17)

Allen County Non-Public School Association

FOR ALL KINDERGARTEN STUDENTS

KINDERGARTEN VISION EXAMINATION

Name _____ Birthdate _____
(Last) (First) (MI)

Address _____

Examiner's Report

VISUAL ACUITY

	NEAR	FAR
R eye	_____	_____
L eye	_____	_____
Both	_____	_____

REFRACTION ERROR TEST

Results _____

OCULAR HEALTH TEST

Results _____

BINOCULAR COORDINATION TEST

Results _____

Has the Parent/Guardian been informed of any abnormalities or vision problems needing attention? YES _____ NO _____

Additional remarks or information which you feel might be of assistance to the school in promoting good vision health for this student:

_____

_____

Examining Eye Doctor's Signature _____ Date _____

Stamped or Printed Name, Address and Phone Number of Examining Eye Doctor:

_____

_____

_____

(rev ACNPSA 1/17)