



HOPEWELL AREA SCHOOL DISTRICT

CHARLES M. REINA, Ed.D., Superintendent

HOPEWELL HIGH SCHOOL
1215 LONGVUE AVENUE
ALIQUIPPA, PENNSYLVANIA 15001-4599
PHONE 724-378-8565

Dear Parent/Guardian:

You have elected to have a private vision examination for _____. A vision exam is mandated by the state of Pennsylvania yearly. Please have your eye doctor complete the lower portion of this form for his/her permanent health record. You are then requested to return the form to the office of the school nurse. If your child is now under the care of an eye doctor have the form completed and returned. If you have any questions, please call your school nurse.

Sincerely,
Hopewell Area School Nurses

Child's Name _____ Date _____

Visual Acuity - Without Lenses:

R. _____ L _____ Both _____

With Lenses:

R. _____ L _____ Both _____

Diagnosis _____

Glasses prescribed: ☐ Yes ☐ No For Constant wear: ☐ Yes ☐ No

Special seating advises: ☐ Yes ☐ No

Other recommendations: _____

Signature Eye Doctor:

Print Name: