SPRINGVILLE COMMUNITY SCHOOL DISTRICT
400 Academy Street
Springville, Iowa 52336

Administrative Office
319-854-6197
Pat Hocking, Superintendent
Stacey Matus, Bd. Sec./Bus. Mgr.
Barb Hennings, Central Office Sec.

Secondary School
319-854-6196
Nick Merritt, Principal/AD
Melissa Murphy, School Counselor

Elementary School
319-854-6195
Shannon Robertson, Principal
Jaclyn Lussenhop, School Counselor

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Dear Parent/Guardian:

According to Iowa Law, 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.

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 Kindergarten and no later than six months after the date of child's enrollment into both the Kindergarten.

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

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.

Although a comprehensive eye examination by an ophthalmologist or optometrist meets the requirement of vision screening, it is not a requirement to have a full comprehensive exam.

Please have the Certificate of Vision Screening form completed and returned to the school by registration, before the start of the school year. Other vision screening forms are accepted but must include all information as indicated on the Certificate of Vision Screening.

For more information on Vision Screening you may visit:
https://www.legis.iowa.gov/docs/publications/LGE/85/SF419.pdf

If you have questions, please do not hesitate to contact me.

Sincerely,

Lindsay Stocki MSN, RN
Springville School Nurse
lstocki@springville.k12.ia.us

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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: _____

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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