Alabama Lions Sight Conservation Association
Vision Screening Record

SECTION 1 (To be completed by Adult, Parent or Guardian)

Last Name ___________________________ First Name ___________________________ □ Male □ Female DOB _______ Age ___

Phone 1 ( ) ___________________________ Phone 2 ( ) ___________________________

Address ___________________________ Apt # __________ City ___________________________

State _______ Zip ___________ County ___________________________

Does the person being screened wear glasses or contacts? □ yes □ no □ Glasses lost or broken? 

If yes, please ensure the person is wearing glasses or contacts on date of screening.

Does he/she wear them for: □ Distance vision □ Close-up vision □ Both

□ Check if you already know the person has serious vision problems or an eye disease.

Has the individual had an eye exam in the past 12 months? □ yes □ no

Have you noticed any abnormalities in your/their behavior such as squinting, excessive blinking, head tilting, etc. or have had complaints of nausea, dizziness, headaches, blurred vision, etc.? If yes, please explain:

____________________________________

____________________________________

____________________________________

Do you need financial assistance with eye care? □ yes □ no

SECTION 2 (To be completed by Vision Screener)

FIRST VISUAL ACUITY SCREENING: Screener completes

Right Eye: 20/____ Left Eye: 20/____ Passing Line 3-5 years: 20/40

Not necessary to screen: _______ 6 years +: 20/30

Unable to screen: _______

Contacts or glasses worn: _______ Screener: __________

SECOND VISUAL ACUITY SCREENING: Screener completes

Right Eye: 20/____ Left Eye: 20/____ Passing Line 3-5 years: 20/40

Not necessary to screen: _______ 6 years +: 20/30

Unable to screen: _______

Contacts or glasses worn: _______ Screener: __________

MUSCLE BALANCE: Screener completes

First screening: ____ Pass ____ Fail

Second screening: _____ Pass _____ Fail

Unable to screen: _______ Screener: __________

BEHAVIOR: Screener completes

List any behavioral observations such as squinting, excessive blinking, head tilting, etc.

____________________________________

____________________________________

____________________________________

FOLLOW UP: Screener completes

Referred to _______________ Lions Club? _______ Yes _______ No

Letter to parent / guardian mailed: _____ yes

Referred to __________________________

Date: ___________________________