

Student Name: _____ Date of Birth: _____ Grade: _____
(Please print: Last Name, First Name)

Student ID: _____

For information about vision requirements see [2013 Oregon HB3000 Section 1: \(2\)\(a\) through \(3\)\(b\)](#) For information about dental requirements see [2015 Oregon HB2972 Section 1: \(2\)\(a\) through \(3\)\(c\)](#)

_____ Vision and Dental Screening Certifications.

_____ My Child has received a vision screening.

Most recent screening or eye exam date: _____ Was a follow-up recommended? (circle) Yes or No

Name of provider: _____