



Vision Examination Form

Child's Name: _____
Child's Date of Birth _____
Date of Exam: _____

Results of Examination

Does the child need glasses _____

If yes, are the glasses to be worn for:

- _____ Close Vision
- _____ Far Vision
- _____ Both Near and Far Vision

Please list the prescription below (if applicable)

	SPHERE	CYL	AXIS	PRISM	BASE
OD					
OS					

Expiration Date: _____

	ADD	SEG STYL	P.D.		
OD					
OS					

Are there other vision/eye problems present? _____

If yes, please describe: _____

Glasses prescribed? _____

Does the child need to be seen for follow-up? _____

If yes when? _____

Date of Exam: _____

Optometrist's Signature: _____

Optometrist's Printed Name: _____

Optometrist's Address: _____

Please Return to:
Adriel
5501 Nebraska Ave.
Toledo, OH 43615
Fax: 888-851-1154