



# 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 Foster Care and Adoption  
 105 Commerce Park Drive, Unit A,  
 Westerville, Ohio 43082  
 Fax: (888) 925-0304