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:_____

Please Return to:
Adriel Foster Care and Adoption
5940 Venture Drive Suite A

Dublin, OH 43017

Optometrist's Address:_____ Fax: (888) 925-0304