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
521 S. Shannon St.
Van Wert, OH 45891
Fax: (888) 241-9316