



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
 414 N. Detroit Street

Optometrist's Address: _____

West Liberty, OH 43357
Fax: (888) 925-1725