Athens County Children Services

Eye Examination Form

Child's Name:_____________________________ DOB:__________________

I have given a complete eye exam with the following diagnosis and recommendations:

		Distance	Near		Distance	Near
Vision without Correction	**O.D.**			**O.S**		
Vision with Correction	**O.D.**			**O.S.**		

Muscle Balance _______________________ Color Test________________
Stereopsis _______________________
Eye Defects ____

Recommendations/ Conclusions
1. Normal eye Examination________________________
2. Corrective lens prescribed: Yes _____ No _____
3. Re-examine in _______________ (Date of return visit)
4. Other____

(Preferential seating, low vision, aides, etc.)

Date ___________________ Signature_________________________________

Please Print:

Name of Physician____
Address____
Phone____