

## 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
<b><u>Vision without Correction</u></b>	O.D.			O.S	
<b><u>Vision with Correction</u></b>	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 \_\_\_\_\_