

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
<u>Vision without Correction</u>	O.D.			O.S	
<u>Vision with Correction</u>	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 _____