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_____