Optical Exam

Child's name _____

Date of Birth _____

Date of Examination _____

External observation: _____

_____

Internal opthalmoscopy: _____

_____

_____

Distance acuity testing: _____

_____

_____

Complete ocular muscle balance test (Children 3-20 years)

_____

_____

Treatment and or prescription: _____

_____

Are glasses required for this child? Yes_____ No_____

Recommendations: _____

_____

_____

Is a follow up appointment necessary? Yes_____ No_____

When does the children need to return for another examination? _____

Doctor's signature _____

AND

Doctor's name stamp