

KEEPING KIDS SAFE, INC.
Foster Care Agency

OPTICAL EXAM FORM

CHILD'S NAME _____ DATE _____

VISUAL ACUITY: WITH GLASSES R _____ L _____ BOTH _____

WITHOUT GLASSES R _____ L _____ BOTH _____

DIAGNOSIS:

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

	Normal	Abnormal	Not able to Assess
External Exam (eye and Adnexa)			
Internal Exam (media, lens, fundus, etc.)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and Convergence			
Color Vision			

GLASSES PRESCRIBED: YES _____ NO _____

RECOMMENDATION FOR WEARING GLASSES: _____

COMMENTS: _____

OPTOMETRIST'S NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

Signature: _____

OPTOMETRIST / OPHTHALMOLOGIST