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

AGENCY USE ONLY
Adult who attended appt: ___________________________________Signed: __________________________
By signing I acknowledge I was present, understand the diagnosis, medications and/or recommendations
CW who received med form: ___________________________ Signed: ______________________________
By signing I acknowledge I received the information and documented any necessary changes