

Vision Record Form for Children in Substitute Care

Child's Name:

Date of Birth:

Doctor's Name:

Date of Exam:

Address:

Type of Examination

- Initial Exam
- Annual Check-up
- Other:

Significant Vision Problems Yes No

Diagnosis: _____

Type Of Exam Received By Child: _____

Treatment and Recommendations: _____

Date Of Next Examination: _____

Doctor's Name:

_____ Date: _____

Please print

Signature

Please Return:

Mail to: Stark County Job & Family Services
Children Services Division
402 2nd Street SE
Canton, OH 44702

or Fax to: (330) 451-8706