Community Care Resources, Inc.

Partnership in Planning

VISION EXAMINATION

Name of Youth:_____ **Date of Birth:**_____

Date of Examination:_____ **Foster Parents:**_____

Right Eye: ___Farsighted ___Astigmatism ___Nearsighted ___Presbyopia ___Amblyopia

Left Eye: ___Farsighted ___Astigmatism ___Nearsighted ___Presbyopia ___Amblyopia

Present Visual Acuity: **Right**_____ **Left**_____

Eye Teaming: ___Poor ___Fair ___Good **Depth Perception:** ___Poor ___Fair ___Good

A Vision Correction is: ___Not indicated ___Definitely needed ___Optional

Glasses should be worn: ___All the time ___As needed ___Far only ___Near only

Recommendations

Type of Contact Lenses:_____

Type of Glasses:_____ **Lens Type:**_____

Tint Or Lens Color:_____

Rx **Right**_____ **Left**_____

Add_____

Your Next Examination Should Be: ___One year ___Two years ___Other_____

Signed_____**,OD** **Date:**_____

Name of Clinic_____

Address_____

☐ ***Child is too young for Vision Exams outside of Pediatric Exams. Vision Exams should begin once child is _____ years old.***
Physician Signature: _____ ***Date:***_____

AFTER EXAMINATION, PLEASE RETURN TO: ***COMMUNITY CARE RESOURCES, Inc.***

Form Updated 02/2018

6716 Stone Glen Drive • Middleton, WI 53562 • (608) 827-7100 • FAX (608) 827-7101

www.CommunityCareResources.com