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:_____

Signed_____ **Date:**_____

Name of Clinic_____

Address_____

☐ ***Child was screened by Physician at Physical Exam and does not need a Vision Exam at this time.***

Notes:

Physician Signature: _____ ***Date:***_____

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

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www.CommunityCareResources.com