**Wesley Spectrum Foster Care**

**Report of Vision Examination**

*To be completed by the treating medical or dental personnel*

*at the time of the child’s appointment*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB/Grade \_\_\_\_\_\_\_\_\_\_

Visual Acuity: Without Lenses R.E. \_\_\_\_ L.E. \_\_\_\_ Both \_\_\_\_\_

With Lenses R.E. \_\_\_\_ L.E. \_\_\_\_ Both \_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glasses Prescribed: Yes \_\_\_\_\_ No\_\_\_\_

Constant Wear: Yes \_\_\_\_\_ No\_\_\_\_

Special Sitting in Classroom: Yes \_\_\_\_\_ No\_\_\_\_

Further care recommended: Yes \_\_\_\_\_ No\_\_\_\_

Other Recommendations

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| --- |
|  |

Examiner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examiner’s Signature

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3/12 Form No: PLPH2

**Revised 11/7/14**