



Vision Form

To be completed for all children 3 years of age and older

Name of Child: _____

Date of Birth: _____

			Check if:	
			Untestable	Referral Recommended
Vision- without glasses	R	L		
Vision- with glasses	R	L		
Vision- near point	R	L		
Color Vision	P	F		

Physician's Signature: _____

Date: _____

Revised 04/2023