H.O.P.E
Helping Others Prosper Everyday

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FOSTER CHILD OPTICAL EXAM

Name of Foster Child: _____

Name of Optometrist: _____
Address of Optometrist: _____
Phone Number of Optometrist: _____

Date of Optical Exam: _____

OPTOMETRIST USE ONLY:

Acuity Without Correction: **O.D.**_____/_____ **O.S.**_____/_____

Acuity With Correction: **O.D.**_____/_____ **O.S.**_____/_____

Prescription: **O.D.**_____/_____ **O.S.**_____/_____

Test for Glaucoma: ☐ **Positive** ☐ **Negative**

Other Comments:

_____
_____
_____

_____ _____
Optometrist Signature **Date**

_____
Printed Name