# Kids Count Too, Inc.

Foster Care & Adoption Agency

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## Optical Exam

Child's Name: _____ DOB: _____ Date of Exam: _____

To Be Completed By Examining Doctor

Ocular History: ☐ Normal Or Positive for: _____
Medical History: ☐ Normal Or Positive for: _____
Drug Allergies: ☐ NKDA Or Positive for: _____
Other Information: _____

**Examination:**

| Refraction: | Distance | | | Near |
|---|---|---|---|---|
| | Right | Left | Both | Both |
| Unaided Visual Acuity | 20 / | 20 / | 20 / | 20 / |
| Best Corrected Visual Acuity: | 20 / | 20 / | 20 / | 20 / |

Was refraction performed with cycloplegic agents? ☐ Yes ☐ No

| | Normal | Abnormal | Not Able to Assess | Comments |
|---|---|---|---|---|
| External Exam(eye and adnexa) | ☐ | ☐ | ☐ | |
| Internal Exam (media, lens, fundus, etc | ☐ | ☐ | ☐ | |
| Neurological Integrity (pupils) | ☐ | ☐ | ☐ | |
| Binocular Function (stereopsis) | ☐ | ☐ | ☐ | |
| Accommodation and Vergence | ☐ | ☐ | ☐ | |
| Color Vision | ☐ | ☐ | ☐ | |
| IOP (glaucoma) | ☐ | ☐ | ☐ | |
| Oculomotor Assessment | ☐ | ☐ | ☐ | |
| Other | ☐ | ☐ | ☐ | |

**Diagnosis**

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia
Other: _____

**Recommendations:**

1. Corrective Lenses: ☐ No ☐ Yes ☐ Constant Wear ☐ Near Vision ☐ Far Vision
   ☐ May be removed for Physical Education
2. Preferential seating recommended: ☐ No ☐ Yes Comments: _____
3. Recommend re-examination: ☐ 3 Months ☐ 6 Months ☐ 12 months ☐ Other: _____
4. _____
5. _____

Optometrist Name (Print): _____ Address: _____

_____

Signature: _____ Phone: _____