



House of New Hope

8135 Mt. Vernon Rd. St. Louisville, Ohio 43071

Tel: (888) 200-1296 Fax: (740) 745-3429

Optical Examination

(Optical Examination required every 2 years or earlier if needed OR every year if the child wears glasses.)

Date of Exam _____

Child's Name _____

Date of Birth _____

Does the child need corrective lenses? _____

If yes, glasses to be worn for: ____ Close Vision ____ Far Vision ____ Both

Abnormal Findings from Optometric Exam:

Optometrist's Recommendations:

Follow-Up Visit Date: _____

Print or Type

Doctor's Name: _____

Office Address: _____

City/State/Zip: _____

Office Telephone: _____ Fax: _____

Doctor's Signature/Date: _____