PICAYUNE SCHOOL DSTRICT
EARLY HEAD START/HEAD START

EYE EXAM FORM

CHILD'S NAME:_____DOB:_____
DATE OF SERVICE:_____ALLERGIES_____
MEDICAL PROVIDER:_____

EYE EXAM:	WNL _____	NOT WNL _____
COMMENTS: _____		

WEARS GLASSES:	YES _____	NO _____
NEW Rx for GLASSES:	YES _____	NO _____

FOLLOW-UP NEEDED?	YES _____	NO _____
NEXT SCHEDULED APPOINTMENT: _____		

_____
MEDICAL PROVIDER'S SIGNATURE