

**TUSCARAWAS COUNTY JOB & FAMILY SERVICES  
VISION RECORD FORM FOR CHILDREN IN SUBSTITUTE CARE**

**PLEASE PRINT**

CHILD'S NAME	DATE OF BIRTH
DOCTOR'S NAME	DATE OF EXAM
ADDRESS	

**TYPE OF EXAMINATION**

- INITIAL EXAM
- ANNUAL CHECKUP
- OTHER: \_\_\_\_\_

<b>SIGNIFICANT VISION PROBLEMS</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Diagnosis:</b>		

<b>TYPE OF EXAM RECEIVED BY CHILD</b>
<b>TREATMENT AND RECOMMENDATIONS</b>

**DATE OF NEXT EXAMINATION** \_\_\_\_\_

\_\_\_\_\_  
**DOCTOR'S SIGNATURE**

\_\_\_\_\_  
**DATE**

<b>Please Return:</b>	<b>Mail to:</b> Tuscarawas County Job & Family Services 389 16 <sup>th</sup> Street, SW New Philadelphia, Ohio 44663	<b>or</b>	<b>Fax to:</b> 330-308-7790
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