 *** *Fill out this side before the exam* ***

Child's name: Date of the exam:

Doctor's name:

Reasons for making the appointment (failed vision screening, noticed vision issues, family history, etc):

Family history of eye problems, especially at a young age:

Medications that your child is currently on:

Other medical conditions that your child has:

Questions you want to be sure to have answered at this exam:

 **** Fill out this side during the exam ****

Does my child have a vision disorder? What is it?

Do you have more information about it or recommendations of where I can learn more?

Which eye(s) is affected: Right Left Both

Treatment:	☐ Glasses: When should they be worn (all day, reading only)? ☐ Contacts: How long should they be worn before removing and cleaning? ☐ Eye drops: Which eye? How often? ☐ Patching: Which eye? How long? ☐ Other:	Treatment Notes:

If I have more questions at a later time, what is the best way to get a hold of you?

When should we make our next appointment for my child?

What things I should watch out for between appointments? What should I do if I see them?

Do you have any recommendations for where I could go to get glasses/contacts/patches etc?

Do my child's siblings need an eye exam?

Other notes: