Thrivalaska Head Start Birth to Five
Verification of Vision Exam

This is to certify that _____ DOB_____

Child's Name

Is one of my patients and was seen for an exam on .

Examination Date

The following applies to this patient:

- ☐ Needs **no treatment** at this time
- ☐ Needs **routine examination** in the month of
- ☐ Needs the **following services/follow-up treatment:**

  _____
- ☐ The patient was **unable to be examined** due to _____
- ☐ An appointment is scheduled for _____

During this visit the following services were performed:

Description of work	Comments

Additional Notes/ Recommendations: _____

Doctor's Signature (REQUIRED): ____ Phone/Fax:_____

Clinic Name: _____ Address: _____

I give permission for the most recent vision exam to be faxed to Thrivalaska Head Start Birth to Five Attn: Health and Safety, at 452-4203.

Form received _____(staff initials) date

Created 10/12

Entered in CP _____(HSC initials) date

Performance Standard Section Health and Safety 1304

Parent Signature:_____ _ Date:___