TRY-AGAIN HOMES INCORPORATED
CHILD’S INITIAL AND PERIODICAL EYE EXAMINATION

This examination is requested by Try-Again Homes Inc. to determine the health of the child in respect to placement in a foster home.

Child’s Name: ____

Date of Birth: _______________________________

Date of Examination: _________________________

Eyes - Right __________

Left __________

Recommendations: ____

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Physician’s
Signature: _________________________________ Date:___________

Note to Physician: Please submit this completed form directly to:

Name: __________________________

Try-Again Homes, Inc.
PO Box 1228
Washington PA 15301-4525