

CHILD'S INITIAL AND PERIODICAL OPTICAL EXAMINATION

THIS EXAMINATION IS REQUESTED BY TRY-AGAIN HOMES INCORPORATED TO DETERMINE THE HEALTH OF THE CHILD IN RESPECT TO PLACEMENT IN A FOSTER HOME.

CHILD'S NAME: _____

BIRTHDATE: _____

DATE OF EXAMINATION: _____

EYES: RIGHT: _____

LEFT: _____

RECOMMENDATIONS:

OPTOMETRIST'S CONTACT INFORMATION:

NAME: _____

ADDRESS: _____

TELEPHONE/FAX: () _____ () _____

(OPTOMETRIST'S SIGNATURE/DATE)

PLEASE SUBMIT THIS COMPLETED FORM DIRECTLY TO:

TRY-AGAIN HOMES, INCORPORATED
103 EUCLID DRIVE
PARKERSBURG, WV 26102