Children's Sanctuary, Inc.

CLIENT EYE EXAMINATION RECORD

CLIENT:		DATE OF BIRTH:	
DOCTOR'S NAME:			
Office Address:		Phone:	
Current Medications:			
Examination Results:			
Recommendations:			
Physician's Signature:		Date of Exam:	

RX

SPHERE	CYL.	AXIS	PRISM	ADD	OTHER
O.D.					
O.S.					

P.D.'s	Dist		Near		Lens Type
Seg. Type:			Absorption:		
Intended use of RX:					
REORDER NUMBER:					