DPP-106F
(R.8/11)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services

VISION SCREENING

CHILD'S NAME: _____ DOB: _____

DCBS CASE NUMBER: _____

DATE OF EXAMINATION: _____

OBSERVATIONS AND/OR RESULTS: _____

_____

_____

_____

_____

_____

_____

DOES CHILD NEED FOLLOW-UP APPOINTMENT? YES _____ NO _____

WHY? _____

_____

_____

_____

DATE OF CHILD'S NEXT APPOINTMENT: _____

EXAMINER'S SIGNATURE: _____

ADDRESS: _____

_____

PHONE: _____

File: Original in Passport Folder
Copy in Professional Section