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: ____

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

WHY? ____

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DATE OF CHILD'S NEXT APPOINTMENT: ____

EXAMINER'S SIGNATURE: ____

ADDRESS: ____

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PHONE: ____

File: Original in Passport Folder
Copy in Professional Section