LIVINGSTON COUNTY HEALTH DEPARTMENT

2300 East Grand River Avenue, Suite 102
Howell, Michigan 48843-7578
www.lchd.org

PERSONAL/PREVENTIVE HEALTH SERVICES
P: (517) 546-9850
F: (517) 546-6995

ENVIRONMENTAL HEALTH SERVICES
P: (517) 546-9858
F: (517) 546-9853

VISION PROGRAM
OPHTHALMOLOGIST/OPTOMETRIST REPORT

☐ Early Childhood ☐ Preschool ☐ School-age

☐ Wore Glasses/Contacts during Screen ☐ Glasses/Contacts not available at time of Screen

Refer on: ☐ Vision ☐ Muscle ☐ 2-Line Difference ☐ + Lens ☐ History ☐ Symptom

Technician Initials: _____

Date: _____ Birthdate: _____
Name: _____ School: _____ Grade: _____
Address: _____
_____

Important: Please have the Doctor complete this form and return to the Livingston County Health Department. **Form may be faxed to LCHD at 517-545-9685 (secure line)** or mailed to above address. Thank you.

Name: _____ **Birthdate:** _____

DOCTOR'S REPORT: **School/Grade:** _____ / _____

VISION Uncorrected R / L / o.u. /
Corrected R / L / if signif /

DEFECT ☐ Myopia ☐ Hyperopia ☐ Astig. ☐ Muscle ☐ Other ☐ None

TREATMENT ☐ Glasses ☐ Exercises ☐ Medical ☐ Surgical
☐ No RX at Present ☐ Not Necessary

FURTHER TREATMENT RECOMMENDED
☐ Medical ☐ Surgical ☐ Exercises
☐ Other ☐ None

RETURN IN:
____ Weeks ____ Months ____ Years

COMMENTS: _____
_____

SIGNED: _____ DEGREE: _____

PRINT NAME: _____ DATE: _____