

Yearly Doctor's Signature Required

Physicians Name: _____

Address: _____

Phone: _____

CHILD NAME: _____

DATE OF BIRTH: _____

_____ was in our office and had
their annual physical exam on: _____.

He/she was found to be in good physical condition and is able to participate in all activities.

DOCTORS SIGNATURE

DATE

HEARING	HZ-1000	HZ-2000	HZ-4000		
Right				PASS	FAIL
Left				<input type="checkbox"/>	<input type="checkbox"/>
VISION	R20/_____	L/20_____		Pass <input type="checkbox"/>	Fail <input type="checkbox"/>

IF YOUR CHILD IS FOUR YEARS OF AGE OR WILL BE TURNING FOUR THIS YEAR, THE STATE REQUIRES THEM TO HAVE A VISION AND HEARING EXAM AT THEIR ANNUAL CHECK-UP.