

CHILD NAME: _____

DATE OF BIRTH: _____

IF YOUR CHILD IS FOUR YEARS OF AGE OR WILL BE TURNING FOUR THIS YEAR THE STATE REQUIRES THEM TO HAVE A PROFESSIONAL EXAMINATION FOR VISION AND HEARING.

Hearing	Date	Signature		
Hz	1000	2000	4000	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
R				
L				
Vision	Date	Signature		
R20		L20		<input type="checkbox"/> Pass <input type="checkbox"/> Fail

_____ was in our office and

had a complete Physical Exam on _____.

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

DOCTORS SIGNATURE

DATE

Physicians Name: _____

Address: _____

Phone: _____