Certificate of Record for

Vision Screening of Lakewood Athletics

Child's Name: ____________________________
Date of Birth:_____________________________
Date of Exam: ____________________________

Vision:

Right: 20/____ Left: 20/_____ ___PASS / ___FAIL

___With correction ___Without correction

Rescreen recommended: ___Yes / ___No

Cleared for participation: ___Yes / ___No

Additional comments: ____
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Physician/Screener Name:_________________________

Physician/Screener Signature or stamp:___________________________________

Date: __________________