Children's Aid Society
of the City of Kingston and County of Frontenac

RECORD OF VISION CARE

Child's Name: _____ **D.O.B._____**

Ophthalmologist/Optometrist's Name:

_____
(PLEASE PRINT)

Date of Examination: _____

Findings/Recommendations:

Date: _____ **Signature of Ophthalmologist/Optometrist:**

_____

PLEASE COMPLETE AND FAX TO FRONTENAC C.A.S. AT: 1(613) 542-4428