Vision Screening Verification

I hereby confirm that_____, presented at
(Patient Name) Please Print

my office on _____, 20___, and was provided with a vision examination.
(Month) (Day)

Signature:_____
Signature of Physician, Nurse Practitioner or Physician Assistant

Printed Name:_____

Date Signed:_____

Provider Address:_____

_____

Phone:_____

Signature:_____
Signature of Participant

School District or College:_____

Zip Code:_____

Date of Birth:_____