Town Center Eye Care
Children under 8 years of age

Name_____

Date of Birth_____

Does your child have ant Sensitivities'? _____
(for example - afraid of darkness, bright lights bothersome, loud noises, etc.)

Does you child have Allergies? _____

Eye Health Any previous Prescriptions? _____

Any previous Treatments? _____

Has your child needed eye patching? _____

Has there been eye disease detected? _____

Any Injuries or Surgeries? _____

How would you describe your child's Coordination? _____

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