Town Center Eye Care
Children under 8 years of age

Name____

Date of Birth_______________________

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

Does your 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? __________________

____