Canadian Vision Care

DATE: _____

NAME: _____

ADDRESS: _____

TOWN: _____

SCHOOL/PHONE#: _____

CC/RX/MEDS		
VA	20/	20/
NEAR	20/	20/

OCULAR HEALTH		I.O.P.

PRESCRIPTION

	SPH	CYL	AXIS	ADD	SEG	HT
R						
L						

FRAME INFO	MODEL:	PD
	SIZE:	
	COLOR:	

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