



# Youth Services Grant - Medical Summary

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Plain PDF form. Print or write on the form to complete.

## Patient

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**Patient Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

## Examination

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**Examination Date** \_\_\_\_\_

**Examining Professional** \_\_\_\_\_

**Specialty** \_\_\_\_\_

**Patient is Legally Blind?**

Yes  No

**Vision Description**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Conditions Present?**

Yes  No

**Other Conditions Description**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Professional Signature

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**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Submit with grant application.