

OPTOMETRIC VISUAL TRAINING WORKSHEET

NAME _____ AGE _____ GRADE _____

WEEK OF _____
 Sun. _____ Minutes
 Mon. _____ "
 Tues. _____ "
 Wed. _____ "
 Thurs. _____ "
 Fri. _____ "
 Sat. _____ "

WEEK OF _____
 Sun. _____ Minutes
 Mon. _____ "
 Tues. _____ "
 Wed. _____ "
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 Fri. _____ "
 Sat. _____ "

Parent's Signature _____ Parent's Signature _____

WEEK OF _____
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WEEK OF _____
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Parent's Signature _____ Parent's Signature _____

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Parent's Signature _____ Parent's Signature _____

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