



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to October 15 of the year the child enters an Illinois school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Sex _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of Exam _____

Ocular History: Normal or Positive for _____

Medical History: Normal or Positive for _____

Drug Allergies: NKDA or Allergic to _____

Other Information _____

Examination

| Refraction: | Distance | | | Near |
|------------------------------|----------|------|------|------|
| | Right | Left | Both | Both |
| Unaided Visual Acuity | 20/ | 20/ | 20/ | 20/ |
| Best Corrected Visual Acuity | 20/ | 20/ | 20/ | 20/ |

Was refraction performed with cycloplegic agents? Yes No

| | Normal | Abnormal | Not Able to Assess | Comments |
|---|--------------------------|--------------------------|--------------------------|----------|
| External Exam (eye and adnexa) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Internal Exam (media, lens, fundus, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Neurological Integrity (pupils) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Binocular Function (stereopsis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Accommodation and Vergence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Color Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| IOP (glaucoma) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Oculomotor Assessment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other _____



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Recommendations

1. Corrective Lenses: No Yes, glasses should be worn for:
 Constant Wear Near Vision Far Vision
 May Be Removed for Physical Education

2. Preferential seating recommended: No Yes

Comments _____

3. Recommend re-examination: 3 months 6 months 12 months
 Other _____

4. _____

5. _____

Print name _____
 Optometrist or Physician who provides eye examinations

Address _____

Phone _____

Signature _____
 Optometrist or Physician who provides eye examinations

Date _____

| |
|---|
| <p align="center">Consent of Parent or Guardian</p> <p>I agree to release the above information on my child or ward to appropriate school or health authorities.</p> <p align="center">_____ (Parent or Guardian's Signature)</p> <p align="center">_____ (Date)</p> |
|---|

(Source: Amended at 32 Ill. Reg. _____, effective _____)



State of Illinois Department of Public Health Eye Examination Waiver Form

Please print:

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Sex _____ School _____ Grade _____
(Month/Day/Year)

Address _____
(Number) (Street) (City) (ZIP Code)

Phone _____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All KIDS).

My child is enrolled in Medicaid/All KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to see the child and accepts Medicaid/All KIDS.

My child does not have any type of medical or vision/eye care insurance coverage, and there are no low-cost vision/eye clinics in our community that will see my child.

Signature _____ Date _____

(Source: Added at 32 Ill. Reg. _____, effective _____)