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

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

Parent or Guardian

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

<table>
<thead>
<tr>
<th>Refraction:</th>
<th>Distance</th>
<th>Near</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right</td>
<td>Left</td>
</tr>
<tr>
<td>Unaided Visual Acuity</td>
<td>20/</td>
<td>20/</td>
</tr>
<tr>
<td>Best Corrected Visual Acuity</td>
<td>20/</td>
<td>20/</td>
</tr>
</tbody>
</table>

Was refraction performed with cycloplegic agents? ☐ Yes ☐ No

External Exam (eye and adnexa) Normal Abnormal Not Able to Assess Comments
Internal Exam (media, lens, fundus, etc.) Normal Abnormal Not Able to Assess Comments
Neurological Integrity (pupils) Normal Abnormal Not Able to Assess Comments
Binocular Function (stereopsis) Normal Abnormal Not Able to Assess Comments
Accommodation and Vergence Normal Abnormal Not Able to Assess Comments
Color Vision Normal Abnormal Not Able to Assess Comments
IOP (glaucoma) Normal Abnormal Not Able to Assess Comments
Oculomotor Assessment Normal Abnormal Not Able to Assess Comments
Other Normal Abnormal Not Able to Assess Comments

Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other

Continued on back
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Eye Examination Report

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 ____________________________

Print name ____________________________________________
   Optometrist or Physician who provides eye examinations

Address ________________________________________________

Phone _________________________________________________

Signature _____________________________________________  Date __________
   Optometrist or Physician who provides eye examinations

Consent of Parent or Guardian
   I agree to release the above information on my child or ward to appropriate school or health authorities.

   (Parent or Guardian’s Signature) __________________________
   (Date) __________________________

(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 ____________)

Printed by Authority of the State of Illinois
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