



# State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides 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 the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name \_\_\_\_\_  
 (Last) (First) (Middle Initial)

Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ 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

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation?  Yes  No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (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"/>	_____
Glaucoma evaluation	<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"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

#### Diagnosis

Normal  Myopia  Hyperopia  Astigmatism  Strabismus  Amblyopia

Other \_\_\_\_\_



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## Recommendations

1. Corrective lenses:  No  Yes, glasses or contacts 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 (such as an ophthalmologist)  
 who provided the eye examination  MD  OD  DO

License Number \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Phone \_\_\_\_\_

**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)

Signature \_\_\_\_\_

Date \_\_\_\_\_

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



**State of Illinois  
Department of Public Health  
Eye Examination Waiver Form**

**Please print:**

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name \_\_\_\_\_ Grade Level \_\_\_\_\_ Gender  Male  Female

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 medical assistance/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 examine my child and accepts medical assistance/ALL KIDS.
- My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.
- Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations: \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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