



# 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"><b>Consent of Parent or Guardian</b></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>
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(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 \_\_\_\_\_)