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 ______________)
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

<table>
<thead>
<tr>
<th></th>
<th>Distance</th>
<th>Near</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right</td>
<td>Left</td>
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<tr>
<td>Uncorrected visual acuity</td>
<td>20/</td>
<td>20/</td>
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<tr>
<td>Best corrected visual acuity</td>
<td>20/</td>
<td>20/</td>
</tr>
</tbody>
</table>

Was refraction performed with dilation?  □ Yes  □ No

External exam (lids, lashes, cornea, etc.) □ Normal □ Abnormal □ Not Able to Assess □ Comments

Internal exam (vitreous, lens, fundus, etc.) □ Normal □ Abnormal □ Not Able to Assess □ Comments

Pupillary reflex (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

Glaucome evaluation □ Normal □ Abnormal □ Not Able to Assess □ Comments

Oculomotor assessment □ Normal □ Abnormal □ Not Able to Assess □ Comments

Other □ Normal □ Abnormal □ Not Able to Assess □ Comments

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

Continued on back
State of Illinois
Eye Examination Report

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____________________________________________ License Number_____________________________________

Optometrist or physician (such as an ophthalmologist) who provided the eye examination  ❑ MD  ❑ OD  ❑ DO

Address ____________________________________________
____________________________________________

Phone ____________________________________________

Signature ____________________________________________ Date ___________________

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 ___________)

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