

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 15th 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 child beginning school.

Student Name: _____ Birth Date: _____ Sex: _____ Grade: _____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: _____ Phone: _____
(Last) (First) (Area Code)

Address: _____ County: _____
(Number) (Street) (City) (Zip Code)

To Be Completed By Examining Doctor

Date of Exam: _____

Case History

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: _____

Recommendations

- Corrective Lenses: No Yes, glasses should be worn for: Constant Wear Near Vision Far Vision
 May Be Removed for Physical Education
- Preferential seating recommended: No Yes Comments: _____
- Recommend re-examination: 3 months 6 months 12 months Other _____
- _____
- _____

Print Name: _____
Optometrist or Physician Who Provides Eye Examinations

Address: _____

Signature: _____
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)

Phone: _____



EYE EXAMINATION WAIVER FORM

Please print:

Student's Name: Last First Middle			Birth Date: (Month/Day/Year) / /
Address: Street City		ZIP Code	Telephone:
Name of School:	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Address (of parent/guardian):		

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 that 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 _____