## 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:	
(Mo.) (Day)	(Yr.)			
Parent or Guardian:				
	(Last)		(First)	)
Phone:				
(Area Code)				
Address:				
(Number)	(Street)		(City)	(Zip Code)
County:				
То В	e Completed B	y Examining Do	octor	
Case History				
Date of Exam:				
	ositive for:			
Medical History:   Normal or P	ositive for:			
Examination		Distance		
Examination	Right	Left	Both	Near Both
Uncorrected Visual Acuity:	20 /	20 /	20 /	20 /
Best Corrected Visual Acuity:	20 /	20 /	20 /	20 /
Was refraction performed with dilati	on? □ Yes □	l No	L	l

		Normal	Abnormal	Not Ab to Asse	Comments	
External Ex	xam (lids, lashes, cornea, etc.)				55	
	am (vitreous, lens, fundus, etc.)					
	Reflex (pupils)					
	Function (stereopsis)					
	lation and Vergence					
Color Visio	on					
Glaucoma Evaluation						
Oculomotor Assessment						
Other:						
NOTE: "N provide the		nability of	the child to	complet	e the test, not the inability of the doctor to	
Diagnosis						
□ Normal □ Myopia			☐ Hyperopia		☐ Astigmatism	
☐ Strabismus ☐ Amblyopia			Other:			
Recommen	ndations					
1. Corrective Lenses:		□ No	☐ Yes, glasses or contacts should be worn for: ☐ Constant Wear ☐ Near Vision ☐ Far Vision ☐ May Be Removed for Physical Education/Recess			
2. Prefe	erential Seating Recommended:	☐ No	☐ Yes	Comme	nts:	
3. Reco	ommend Re-examination:		□ 3 mont		☐ 6 months ☐ 12 months	
4			☐ Other			
4. 5.					_	
<i></i>						
Print				Lic.		
Name:				_ No.:		
	Optometrist or Physician (such Who Provided the Eye  MD DOD D	Examina		·)		
Address:				- -	Consent of Parent or Guardian  I agree to release the above information on my child or ward to appropriate school or health authorities.	
Phone:				_		
					(Parent's or Guardian's Signature)	
Signature:				_		
Optometrist or Physician (such Who Provided the Ey □MD □OD		Examina		)	Date	
Date:						