

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.

Case Case	Student Name							
Parent or Guardian	D' 4 D 4			1	C	,	· /	(Middle Initial)
Parent or Guardian	Month/Day/Ve		(render	Gra	de		
Clast County	Parent or Guardian	ai)						
Number (Street) (City) (ZIP Code)			(Last)				(First)	
Number (Street) (City) (ZIP Code)	Phone							
County								
County	Address			(Street)			(C:t-)	(ZID Codo)
Case History Date of exam Coular history:							(City)	(ZIF Code)
Case History Date of exam Ocular history:								
Date of exam			To	Be Comp	oleted By	Examinin	ng Doctor	
Date of exam	Case History							
Ocular history: Normal or Positive for								
Medical history: NKDA or Positive for Or Gray allergies: NKDA or Allergic to Other information NKDA or Allergic to			Positive fo	ar.				
Other information NKDA Or Allergic to	•							
Examination Distance	•							
Examination Distance	Drug allergies:	DA or A	Allergic to)				
Near Right Left Both Both Both Uncorrected visual acuity 20/	Other information							
Near Right Left Both Both Both Uncorrected visual acuity 20/	Examination							
Right Left Both Both Uncorrected visual acuity 20/ 20/ 20/ 20/ 20/ 20/ Best corrected visual acuity 20/ 20/ 20/ 20/ 20/ 20/ Was refraction performed with dilation?		Distance	e.		Near	7		
Uncorrected visual acuity				Both		1		
Was refraction performed with dilation?	Uncorrected visual acuity		20/	20/	20/	1		
Normal Abnormal Not Able to Assess Comments External exam (lids, lashes, cornea, etc.)	Best corrected visual acuity	20/	20/	20/	20/			
Normal Abnormal Not Able to Assess Comments External exam (lids, lashes, cornea, etc.)		d 121 /2	0 🗖 37					
External exam (lids, lashes, cornea, etc.)	Was refraction performed with	th dilation	? u Ye	s unc)			
External exam (lids, lashes, cornea, etc.)				Normal	$\mathbf{A}^{\mathbf{I}}$	bnormal	Not Able to Assess	Comments
Internal exam (vitreous, lens, fundus, etc.) Pupillary reflex (pupils) Binocular function (stereopsis) Accommodation and vergence Color vision Glaucoma evaluation Oculomotor assessment Other 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	External exam (lids, lashes, c	ornea, etc	.)			_	_	
Binocular function (stereopsis) Accommodation and vergence Color vision Glaucoma evaluation Oculomotor assessment Other 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		*						
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Color vision								
Color vision	· • • • • • • • • • • • • • • • • • • •							
Oculomotor assessment Other	Color vision							
Other	Glaucoma evaluation							
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 Strabismus Amblyopia	Oculomotor assessment							
Diagnosis □ Normal □ Myopia □ Hyperopia □ Astigmatism □ Strabismus □ Amblyopia	Other							
□ Normal □ Myopia □ Hyperopia □ Astigmatism □ Strabismus □ Amblyopia	NOTE: "Not Able to Assess" re	fers to the	inability of	the child to	complete t	the test, not	the inability of the doctor t	to provide the test.
□ Normal □ Myopia □ Hyperopia □ Astigmatism □ Strabismus □ Amblyopia	Diagnosis							
Other	_	1 Hyperop	oia 🗖	Astigmatis	m 🖵 S	trabismus	☐ Amblyopia	
	Other							

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Recommendations

 Corrective lenses: ☐ No ☐ Yes, glasses or contacts should be ☐ Constant wear ☐ Near vision ☐ May be removed for physical educe 	☐ Far vision
2. Preferential seating recommended: ☐ No ☐ Yes	
Comments	
3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ Other	
4	
5	
Print name Optometrist or physician (such as an ophthalmologist)	License Number
who provided the eye examination \(\bar{\text{MD}} \) \(\bar{\text{DO}} \) \(\bar{\text{DO}} \) \(\bar{\text{DO}} \) \(\bar{\text{Address}} \)	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	(Date)
Signature	Date
(Source: Amended at 32 Ill. Reg.	, effective)