



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

License Number _____

Address _____

Phone _____

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)

Signature _____

Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)



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 _____)