# 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 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 October 15 of the year the child enters an Illinois school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Sex _____ 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**

| **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) | ❑ | ❑ | ❑ | _____ |
| Internal Exam (media, lens, fundus, etc.) | ❑ | ❑ | ❑ | _____ |
| Neurological Integrity (pupils) | ❑ | ❑ | ❑ | _____ |
| Binocular Function (stereopsis) | ❑ | ❑ | ❑ | _____ |
| Accommodation and Vergence | ❑ | ❑ | ❑ | _____ |
| Color Vision | ❑ | ❑ | ❑ | _____ |
| IOP (glaucoma) | ❑ | ❑ | ❑ | _____ |
| Oculomotor Assessment | ❑ | ❑ | ❑ | _____ |
| Other _____ | ❑ | ❑ | ❑ | _____ |

**Diagnosis**

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____



*Continued on back*

# State of Illinois
# Eye Examination Report

**Recommendations**

1. Corrective Lenses: ❑ No ❑ Yes, glasses 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 who provides eye examinations

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 _____
Optometrist or Physician who provides eye examinations

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



Printed by Authority of the State of Illinois
5/08

IISG08-1048