State of Illinois
Department of Public Health

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: ☐ Male ☐ 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 _____

Illinois Department of Public Health, Division of Health Assessment & Screening
217-782-4733 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

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