

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)			(F	irst)	(Middle Initial)
Birth Date		Gender			de	_	
(Month/Day/Yea	•						
Parent or Guardian		(Last)				(First)	
Phone						(1 1131)	
(Area Code)							
Address							
(Numbe	(Street)				(City)	(ZIP Code)	
County							
					Examinin	a Doctor	
		10 L	be Compi	eled by	LAGIIIIIIII	g Doctor	
Case History Date of exam							
Ocular history:	mal or	Positive f	or				
Medical history: ☐ Nor	mal or	Positive f	or				
Drug allergies: ☐ NKI	DA or	Allergic to					
Other information							
Examination							
	Distance	се		Near	7		
	Right	Left	Both	Both			
Uncorrected visual acuity	20/	20/	20/	20/			
Best corrected visual acuity	20/	20/	20/	20/			
Was refraction performed	with dilat	ion? 🗆 Y	′es □ No)			
			Normal	Δŀ	normal	Not Able to Assess	Comments
External exam (lids, lashes	cornea	etc.)		7 ()			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 t	he inability	of the chil	d to comp	lete the tes	t, not the inability of the do	octor to provide the test.
Diagnosis □ Normal □ Myopia □ Other □			•		rabismus	☐ Amblyopia	

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Recommendations

1. Correcti	ive lenses: 🗖 No	☐ Yes, glasses or contacts shown ☐ Constant wear ☐ Near vision ☐ May be removed for physical	on □ Far vision		
2. Prefere Comme	_	mended: 🗖 No 🗖 Yes			
☐ Other	r	on: 3 months 6 months			
Print name Optometrist or physician (such as an ophthalmologist)			License Number		
Address	who provided the eye	e examination	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 or Guardian's Signature) (Date)		
Signature			Date		
	(Sourc	e: Amended at 32 III. Reg	, effective)		