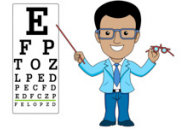


Attached is the vision exam form to be completed by a professional then returned to school.



Vision Exams



To: All Parent(s)/Guardian(s) of Kindergarten Students & New Students entering an Illinois School for the first time.

All children entering kindergarten or enrolling in a public, private, or parochial elementary school in Illinois are required to get a comprehensive eye examination.

-  The examination **MUST** be performed by a licensed optometrist or ophthalmologist.
-  Proof of the examination must be presented to the school health office prior to October 15 of the year of entry.
-  If proof of the examination is not submitted by this date, the school may withhold the child's report card.



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) (First) (Middle Initial)
Birth Date _____ Gender _____ 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

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	☐	☐	☐	_____
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

Other _____



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 _____

Signature _____

Date _____

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)

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