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.

(Last)		(First)		(Middle Initial)
		(First)		(Middle iiitiai)
Birth Date:		Gender:	Grade:	
(Mo.) (Day)	(Yr.)			
Parent or Guardian:				
	(Last)		(First)
Phone:				
(Area Code)				
Address:				
(Number)	(Street)		(City)	(Zip Code)
County:				
ToP	o Completed P	y Examining Do	actor	
	be Completed b	y Examining Du	ctor	
Case History				
Date of Exam:				
	ositive for:			
Ocular History:				
Medical History: Normal or P	ositive for:			
Medical History: ☐ Normal or P Drug Allergies: ☐ NKDA or A	ositive for:			
Medical History: ☐ Normal or P Drug Allergies: ☐ NKDA or A	ositive for:			
Medical History: ☐ Normal or P Drug Allergies: ☐ NKDA or A	ositive for:			
Medical History: ☐ Normal or P Drug Allergies: ☐ NKDA or A Other Information:	ositive for:			
Medical History: ☐ Normal or P Drug Allergies: ☐ NKDA or A	ositive for:			
Medical History: ☐ Normal or P Drug Allergies: ☐ NKDA or A Other Information:	ositive for:	Distance		Near Both
Medical History: Normal or P Drug Allergies: NKDA or A Other Information: Examination	ositive for: Illergic to: Right	Distance Left	Both	Near

		Normal	Abnormal	Not Ab to Asse			
External Ex	xam (lids, lashes, cornea, etc.)			to Asse	SS		
	tam (vitreous, lens, fundus, etc.)	ā	ū				
	Reflex (pupils)						
	Function (stereopsis)						
	dation and Vergence						
Color Vision Glaucoma Evaluation Oculomotor Assessment			_ _				
Other:							
NOTE: "No provide the		nability of	f the child to	complet	e the test, not the inability of the doctor to		
Diagnosis							
□ Normal □ Myopia			☐ Hyperopia		☐ Astigmatism		
☐ Strabismus ☐ Amblyopia			Other:				
Recomme	ndations						
1. Corrective Lenses:		□ No	☐ Yes, glasses or contacts should be worn for: ☐ Constant Wear ☐ Near Vision ☐ Far Vision ☐ May Be Removed for Physical Education/Recess				
	erential Seating Recommended:	□ No	☐ Yes	Comme			
3. Reco	ommend Re-examination:				☐ 6 months ☐ 12 months		
4.							
5.							
Print Name:				Lic.			
ivanic.	Optometrist or Physician (such	as an ophi	thalmologist	<u> </u>			
	Who Provided the Eye	Examina		,			
		D O		Г			
Address:				_	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's or Guardian's Signature)		
Signature:	Optometrist or Physician (such Who Provided the Eye	Examina			Date		
Date:							