

## **Eye Examination Waiver Form**

## Please print: Student Name (Last) (First) Grade Level \_\_\_ Gender: ☐ Male ☐ Female School Name (Street) (City) (ZIP Code) Parent or Guardian (Last) (First) Address of Parent or Guardian \_\_\_\_\_(Number) (Street) (City) (ZIP Code) I am unable to obtain the required vision examination because: My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ ALL KIDS. ☐ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination. Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations: Signature \_\_\_\_\_ (Source: Added at 32 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)