Eye Examination Waiver Form

Please print:

Student Name ____________________________ (Last) ____________________________ (First) ____________________________ (Middle Initial) Birth Date ____________________________ (Month/Day/Year)

School Name ____________________________ Grade Level ______ Gender: □ Male □ Female

Address ___________________________________ (Number) ____________________________ (Street) ____________________________ (City) ____________________________ (ZIP Code)

Phone ___________________________________ (Area 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 __________________________________________ Date ____________________________

(Source: Added at 32 Ill. Reg. ________, effective _______________)

Printed by Authority of the State of Illinois