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) ____________ (First) ____________ (Middle Initial)
Birth Date ____________________________ (Month/Day/Year)
Gender _______ Grade _______

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

<table>
<thead>
<tr>
<th>Distance</th>
<th>Near</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>Left</td>
</tr>
<tr>
<td>Uncorrected visual acuity 20/</td>
<td>20/</td>
</tr>
<tr>
<td>Best corrected visual acuity 20/</td>
<td>20/</td>
</tr>
</tbody>
</table>

Was refraction performed with dilation?  ☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>External exam (lids, lashes, cornea, etc.)</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Not Able to Assess</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal exam (vitreous, lens, fundus, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
</tr>
<tr>
<td>Pupillary reflex (pupils)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
</tr>
<tr>
<td>Binocular function (stereopsis)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
</tr>
<tr>
<td>Accommodation and vergence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
</tr>
<tr>
<td>Color vision</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
</tr>
<tr>
<td>Glaucoma evaluation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
</tr>
<tr>
<td>Oculomotor assessment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
</tr>
</tbody>
</table>

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 ____________________________

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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 _______________________________________

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)

Signature ____________________________________________

Date ____________________

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