

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.

Birth Date	Student Name							
Phone (Area Code) (Area Code) (Area Code) (Area Code) (Area Code) (City) (ZIP Code) (City)	D' 4 D 4			7 1		,	· /	(Middle Initial)
Phone (Area Code) (Area Code) (Area Code) (Area Code) (Area Code) (City) (ZIP Code) (City)	Birth Date(Month/Day/Ve		(Jender	Gra	ade		
Clast Clas	Parent or Guardian	cai)						
Address Number (Street) (City) (ZIP Code)	(Last)						(First)	
Address Number (Street) (City) (ZIP Code)	Phone							
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 Nistance Near	Address	>		(Ctt)			(C:F-)	(7ID C- 1-)
Case History Date of exam Ocular history:	` /			, ,			(City)	(ZIP Code)
Case History Date of exam Ocular history:								
Date of exam			T	o Be Comp	leted By	Examinin	g Doctor	
Date of exam	Case History							
Ocular history: Normal or Positive for	-							
Medical history: NKDA or Allergic to Other information NKDA or Allergic to Other information				•				
Other information Distance	Ocular history:							
Examination Distance	Medical history:	mal or F	ositive f	or				
Examination Distance	Drug allergies:	DA or A	Allergic t	0				
Distance	Other information							
Distance	Other information							
Right Left Both Both Uncorrected visual acuity 20/ 20/ 20/ 20/ 20/ Best corrected visual acuity 20/ 20/ 20/ 20/ 20/ Was refraction performed with dilation?	Examination							
Uncorrected visual acuity		Distance			Near			
Best corrected visual acuity 20/ 20/ 20/ 20/ 20/ Was refraction performed with dilation?		Right	Left	Both	Both			
Was refraction performed with dilation?								
Normal Abnormal Not Able to Assess Comments External exam (lids, lashes, cornea, etc.)	Best corrected visual acuity	20/	20/	20/	20/			
Normal Abnormal Not Able to Assess Comments External exam (lids, lashes, cornea, etc.)								
External exam (lids, lashes, cornea, etc.)	Was retraction performed wi	th dilation'	′ ⊔ Ye	s 🖵 No				
External exam (lids, lashes, cornea, etc.)				Normal	A	ha amaa 1	Not Ablata Aggaga	Commonts
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	External axom (lide laches	aarmaa ata	`		A	_		Comments
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				_			0	
Accommodation and vergence				_		_	<u> </u>	
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				_			_	
Oculomotor assessment Other					_	Ξ		
Other				_		_	Ξ	
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 Strabismus Amblyopia				_		-		
Diagnosis □ Normal □ Myopia □ Hyperopia □ Astigmatism □ Strabismus □ Amblyopia			nability of	_	complete			to provide the test
□ Normal □ Myopia □ Hyperopia □ Astigmatism □ Strabismus □ Amblyopia					- Janpiere	1051, 1101	macing of the doctor	F-1 130 110 1001
	•							
Other	☐ Normal ☐ Myopia ☐	☐ Hyperop	ia 🗖	Astigmatisn	n 🗆 S	Strabismus	Amblyopia	
	Other							

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Recommendations

1. Corrective lenses: ☐ No	☐ Yes, glasses or contacts should be v	worn for:
	☐ Constant wear ☐ Near vision ☐	1 Far vision
	☐ May be removed for physical educ	ation
-	mended:	
Comments		
	on: 3 months 6 months	12 months
4		
5		
		License Number
	hysician (such as an ophthalmologist) ye examination □ MD □ OD □ DO	
Address		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)
Phone		(Date)
Signature		Date
(Sc	ource: Amended at 32 III. Reg.	. effective