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 ______________ Gender _____ Grade _____
(Month/Day/Year)

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

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	________
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

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 ______________________

Address ______________________________

____

Phone ______________________________

Signature ______________________________ Date ______________

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)

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

Printed by Authority of the State of Illinois
6/09

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