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

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

Was refraction performed with dilation? □ Yes □ No

External exam (lids, lashes, cornea, etc.) □ Normal □ Abnormal □ Not Able to Assess □ Comments ____________
Internal exam (vitreous, lens, fundus, etc.) □ Normal □ Abnormal □ Not Able to Assess □ Comments ____________
Pupillary reflex (pupils) □ Normal □ Abnormal □ Not Able to Assess □ Comments ____________
Binocular function (stereopsis) □ Normal □ Abnormal □ Not Able to Assess □ Comments ____________
Accommodation and vergence □ Normal □ Abnormal □ Not Able to Assess □ Comments ____________
Color vision □ Normal □ Abnormal □ Not Able to Assess □ Comments ____________
Glaucoma evaluation □ Normal □ Abnormal □ Not Able to Assess □ Comments ____________
Oculomotor assessment □ Normal □ Abnormal □ Not Able to Assess □ Comments ____________
Other □ Normal □ Abnormal □ Not Able to Assess □ Comments ____________

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 ___________________________ License Number ___________________________
Optometrist or physician (such as an ophthalmologist) who provided the eye examination ☐ MD ☐ OD ☐ DO

Consent of Parent or Guardian
I agree to release the above information on my child or ward to appropriate school or health authorities.

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(Parent or Guardian’s Signature)

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(Date)

Address ____________________________________________

Phone ____________________________________________

Signature __________________________________________

Date ___________________________

(Source: Amended at 32 Ill. Reg. _________, effective ___________)