

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	
(M	Ionth/Day/Year)			
Parent or Guardian	L			
		(Last)	(First)	
Phone				
(Area Code))			
Address				
	(Number)	(Street)	(City)	(ZIP Code)
County				
		To Be Com	pleted 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? \Box Yes \Box 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
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Recommendations		
1. Corrective lenses: \Box No	□ Yes, glasses or contacts should be v	worn for:
	□ Constant wear □ Near vision □	Far vision
	□ May be removed for physical educ	ation
2. Preferential seating recomm	mended: 🗅 No 🕞 Yes	
Comments		
	on: \Box 3 months \Box 6 months \Box	12 months
4		
5		
Print name		License Number
	ysician (such as an ophthalmologist)	
who provided the ey	ye examination \Box MD \Box OD \Box DO	Consent of Parent or Guardian
Address		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

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