

# 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: \_\_\_\_\_  
(Mo.) (Day) (Yr.)

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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary Reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and Vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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: \_\_\_\_\_

**Recommendations**

- Corrective Lenses:                       No                       Yes, glasses or contacts should be worn for:  
 Constant Wear                       Near Vision                       Far Vision  
 May Be Removed for Physical Education/Recess
- Preferential Seating Recommended:                       No                       Yes                      Comments: \_\_\_\_\_
- Recommend Re-examination:                       3 months                       6 months                       12 months  
 Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Print Name: \_\_\_\_\_ Lic. No.: \_\_\_\_\_  
Optometrist or Physician (such as an ophthalmologist)  
Who Provided the Eye Examination  
 MD    OD    DO

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_  
Optometrist or Physician (such as an ophthalmologist)  
Who Provided the Eye Examination  
 MD    OD    DO

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's or Guardian's Signature)

Date \_\_\_\_\_