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.)	❑	❑	❑	
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: _____

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/Recess
2. Preferential Seating Recommended: ❑ No ❑ Yes Comments: _____
3. Recommend Re-examination: ❑ 3 months ❑ 6 months ❑ 12 months
   ❑ Other _____
4. _____
5. _____

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 _____