DEPARTMENT OF PUBLIC HEATLH

NOTICE OF PROPOSED AMENDMENTS

Waiver Form is submitted.

(Source: Added at 33 Ill. Reg. _____, effective _____)

Section 665.APPENDIX A Illinois Department of Public Health Eye ~~Vision~~ Examination Report

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 15th 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 October 15 of the 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: _____ Sex: _____ 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

Refraction:	**Distance**			**Near**
	Right	Left	Both	Both
Uncorrected Visual Acuity:	20/	20/	20/	20/
Best Corrected	20/	20/	20/	20/

Visual Acuity:				

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (lids, lashes, cornea, etc)	❑	❑	❑	
Internal Exam (vitreous, lens, fundus, etc.)	❑	❑	❑	
Pupillary Reflex	❑	❑	❑	
Binocular Function (stereopsis)	❑	❑	❑	
Color Vision	❑	❑	❑	
Glaucoma Evaluation	❑	❑	❑	
Oculomotor Assessment	❑	❑	❑	
Other:	❑	❑	❑	

NOTE: "Not able to Assess" refers to the inability to complete the test, not the inability to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism

❑ Strabismus ❑ Amblyopia

Other: _____

Recommendations

1. Corrective Lenses: ❑ No ❑ Yes, glasses 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: _____
❑ OD ❑ MD ❑ DO

Address: _____

_____

Phone: _____

Signature: _____

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 _____