

**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 _____