State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete 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 October 15 of the year the child enters an Illinois school.

Student Name ____________________________ (Last) ____________________ (First) ____________________ (Middle Initial)
Birth Date ____________________ (Month/Day/Year) Sex ______ Grade ______
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

<table>
<thead>
<tr>
<th>Refraction:</th>
<th>Distance</th>
<th>Near</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right</td>
<td>Left</td>
</tr>
<tr>
<td>Unaided Visual Acuity</td>
<td>20/</td>
<td>20/</td>
</tr>
<tr>
<td>Best Corrected Visual Acuity</td>
<td>20/</td>
<td>20/</td>
</tr>
</tbody>
</table>

Was refraction performed with cycloplegic agents? □ Yes □ No

External Exam (eye and adnexa) Normal □ Abnormal □ Not Able to Assess □ Comments ____________________________
Internal Exam (media, lens, fundus, etc.) Normal □ Abnormal □ Not Able to Assess □ Comments ____________________________
Neurological Integrity (pupils) Normal □ Abnormal □ Not Able to Assess □ Comments ____________________________
Binocular Function (stereopsis) Normal □ Abnormal □ Not Able to Assess □ Comments ____________________________
Accommodation and Vergence Normal □ Abnormal □ Not Able to Assess □ Comments ____________________________
Color Vision Normal □ Abnormal □ Not Able to Assess □ Comments ____________________________
IOP (glaucoma) Normal □ Abnormal □ Not Able to Assess □ Comments ____________________________
Oculomotor Assessment Normal □ Abnormal □ Not Able to Assess □ Comments ____________________________
Other ____________________________

Diagnosis
□ Normal □ Myopia □ Hyperopia □ Astigmatism □ Strabismus □ Amblyopia

Other ____________________________

Continued on back
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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 ____________________________
   Optometrist or Physician who provides eye examinations

Address ______________________________
______________________________

Phone _______________________________
______________________________

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)

Signature ____________________________
   Optometrist or Physician who provides eye examinations

Date ______________________________

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