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 ____________________________
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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 ____________________________

Signature ____________________________
Optometrist or Physician who provides eye examinations

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) ____________________________

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