State of Illinois
Illinois Department of Public Health

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 _____ (Month/Day/Year) Gender _____ Grade _____

Parent or Guardian _____ (Last) _____ (First)

Phone _____ (Include Area Code)

Student Address _____ (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

Exam	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

Exam	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 _____

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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

2. Preferential seating recommended: ☐ No ☐ Yes
   Comments
   _____

3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ 12 months
   ☐ Other _____

4. _____

5. _____

Print name _____ ☐ MD ☐ OD ☐ DO
Optometrist or physician (such as an ophthalmologist) who provided the eye examination

License number _____

Address

_____

Phone _____

Signature _____ 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 or
Guardian's Signature _____ Date _____

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