**Section 665.APPENDIX A Illinois Department of Public Health Eye 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 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 Ableto 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**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/Recess |
| 2. | Preferential Seating Recommended: | ❑ No | ❑ Yes | Comments: |  |
| 3. | Recommend Re-examination: |  | ❑ 3 months | ❑ 6 months | ❑ 12 months  |
|  |  |  | ❑ Other  |  |
| 4. |  |
| 5. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Print Name: |  | Lic.No.: |  |
|  | Optometrist or Physician (such as an ophthalmologist) Who Provided the Eye Examination |  |  |
|  | ❑MD ❑OD ❑DO |  |  |
| Address: |  |  | **Consent of Parent or Guardian**I agree to release the above information on my child or ward to appropriate school or health authorities. |
|  |  |  |
| Phone: |  |  |
|  |  |  |  |  |  |
| Signature: |  |  | (Parent's or Guardian's Signature) |
|  | Optometrist or Physician (such as an ophthalmologist) Who Provided the Eye Examination |  | Date |  |  |
|  | ❑MD ❑OD ❑DO |  |  |
| Date: |  |  |  |

(Source: Amended at 33 Ill. Reg. 8459, effective June 8, 2009)