



# 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 \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_  
(Month/Day/Year)

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**

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity	20/	20/	20/	20/
Best Corrected Visual Acuity	20/	20/	20/	20/

Was refraction performed with cycloplegic agents?     Yes     No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Exam (media, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Integrity (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"/>	_____
IOP (glaucoma)	<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"/>	_____

**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)

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