## Illinois **Eye Examination Report**

(Approval Pending)

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<sup>th</sup> 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 child beginning school.

Student Name:				Birth Date:		_ Sex:	Grade:
(Last)	(First)	(Midd	le Initial)		(Day) (Yr.)		
Parent or Guardian:	(Last)		(First)	<del></del>	Phone:	(Area Code)	
Addross:	,		(1 1131)				
Address:(Number)	(Street)		(City) (Zi	ip Code)	_ County		
		To Be Compl	leted By Exam	ining Doctor			
Case History					Date of E	Exam:	
	☐ Normal ☐ Normal ☐ None	or Positive for: _ or Allergic to:					
Examination							
Refraction:			Distance		1	Near	
Unaided Visua Best Corrected Visua	al Acuity: 20 /	20 / 20 /	Left	Both 20 / 20 /	20 / 20 /	Both	-
Was refraction perform	ned with cyclople	gic agents? 🚨	Yes □ No				
External Exam (eye ar Internal Exam (media, Neurological Integrity (Binocular Function (ste Accommodation and Vaccommodation and Vaccommodation)  Open (glaucoma)  Oculomotor Assessment	lens, fundus, etc (pupils) ereopsis) /ergence		Abnormal	Not Able to Ass			ments
Diagnosis							
□ Normal □	Myopia	☐ Hyperopia	☐ Astiç	gmatism	□ Strabis	mus	Amblyopia
Other:							
Recommendations							
<ol> <li>Corrective Lenses</li> <li>Preferential seating</li> <li>Recommend re-example</li> </ol>	recommended:	es, glasses shoul  No Yes 3 months		■ May Be Re	moved for I	Physical Ed	lucation
4							
Print Name:  Optometrist or Physician Who Provides Eye Examinations  Address:				I agree to releas to appi	e the above info ropriate school	ent or Guardia formation on my or health author an's Signature)	child or ward ities.
Signature:				Phone:			

Optometrist or Physician Who Provides Eye Examinations