



State of Illinois Eye Examination Report

Student Name _____ (Last) _____ (First) _____ (Middle Initial)

Birth Date _____ (Month/Day/Year) Gender _____ 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

| | 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 Able to Assess | Comments |
|--|--------------------------|--------------------------|--------------------------|----------|
| External exam (lids, lashes, cornea, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Internal exam (vitreous, lens, fundus, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Pupillary reflex (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"/> | _____ |
| Glaucoma evaluation | <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"/> | _____ |

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

License Number _____

Address _____

Phone _____

| |
|---|
| <p align="center">Consent of Parent or Guardian</p> <p>I agree to release the above information on my child or ward to appropriate school or health authorities.</p> <p align="center">_____ (Parent or Guardian's Signature)</p> <p align="center">_____ (Date)</p> |
|---|

Signature _____

Date _____

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