

Doctor must complete report,  
parents please return report  
to your child's school or

### State of Illinois Eye Examination Report

send report to Katheryn Hudson,  
healthforms@cps.edu or  
fax 773-535-8677

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) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Last) (First) (Area Code)

Address: \_\_\_\_\_ County: \_\_\_\_\_  
(Number) (Street) (City) (Zip Code)

**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: \_\_\_\_\_

#### Recommendations

- Corrective Lenses:  No  Yes, glasses should be worn for:  Constant Wear  Near Vision  Far Vision  
 May Be Removed for Physical Education
- Preferential seating recommended:  No  Yes Comments: \_\_\_\_\_
- Recommend re-examination:  3 months  6 months  12 months  Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Print Name: \_\_\_\_\_  
Optometrist or Physician Who Provides Eye Examinations

Address: \_\_\_\_\_  
\_\_\_\_\_

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)

Phone: \_\_\_\_\_