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

# State of Illinois
# Eye Examination Report

send report to Katheryn Stafford-Hudson, kgstafford-h@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 15th 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) | ❑ | ❑ | ❑ | _____ |
| Internal Exam (media, lens, fundus, etc.) | ❑ | ❑ | ❑ | _____ |
| Neurological Integrity (pupils) | ❑ | ❑ | ❑ | _____ |
| Binocular Function (stereopsis) | ❑ | ❑ | ❑ | _____ |
| Accommodation and Vergence | ❑ | ❑ | ❑ | _____ |
| Color Vision | ❑ | ❑ | ❑ | _____ |
| IOP (glaucoma) | ❑ | ❑ | ❑ | _____ |
| Oculomotor Assessment | ❑ | ❑ | ❑ | _____ |
| Other: _____ | ❑ | ❑ | ❑ | _____ |

**Diagnosis**

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other: _____

**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: _____

_____

Signature: _____
Optometrist or Physician Who Provides Eye Examinations

Phone: _____

**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)