

Dear Parents,

The Illinois General Assembly recently passed Public Act 095-0671, amending the School Code to mandate vision examinations in kindergarten students and students entering school for the first time. In accordance with this law, the State of Illinois Department of Public Health has adopted new rules regarding vision examinations

- Kindergarteners or students entering school for the first time should have an eye examination and present proof of the examination *to the child's school* by October 15th of the school year.
- Given the nature of the testing required, in most cases the vision examination must be completed by a licensed ophthalmologist or optometrist..
- The state form should be used by the ophthalmologist or optometrist for the vision exam and then returned by you *to your school*.
- The test includes at a minimum: history, visual acuity, subjective refraction, internal and external examination, glaucoma evaluation, as well as, any other tests or observations that in the professional judgment of the doctor are necessary.
- A waiver form from the state should be submitted *to your school* if a family cannot complete the vision examination.
- The screenings for vision and hearing that occur for preschool and school age children are governed by the Illinois Child Vision and Hearing Test Act and are different than this new vision examination rule. Vision screening is required for preschoolers (ages 3, 4, 5), kindergarten, second and eighth graders in childcare agencies, public, private and parochial schools. Schools and preschools are still required to offer vision screening for the mandated grades.

For specific wording of this new legislation go to: [www.ILGA.gov](http://www.ilga.gov) and search for SB641.

For copies of the forms go to: <http://www.idph.state.il.us/>

Copies of the state form and waivers are included in this document. The state form should be taken to the eye doctor when your child is examined.

Thank you for your attention to this matter. If you have additional questions please contact us.

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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 _____



State of Illinois Eye Examination Report

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 _____)



State of Illinois Department of Public Health Eye Examination Waiver Form

Please print:

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

Birth Date _____ Sex _____ School _____ Grade _____
(Month/Day/Year)

Address _____
(Number) (Street) (City) (ZIP Code)

Phone _____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All KIDS).

My child is enrolled in Medicaid/All KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to see the child and accepts Medicaid/All KIDS.

My child does not have any type of medical or vision/eye care insurance coverage, and there are no low-cost vision/eye clinics in our community that will see my child.

Signature _____ Date _____

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