



State of Illinois Eye Examination Report



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 _____

License Number _____

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

Address _____

Phone _____

Signature _____

Date _____

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)

 (Date)

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