





# 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 \_\_\_\_\_

<p align="center"><b>Consent of Parent or Guardian</b></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 \_\_\_\_\_  
 Optometrist or Physician who provides eye examinations

Date \_\_\_\_\_

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

