| Illinois [ | Department of | Public | Health |
|------------|---------------|--------|--------|
| VISION     | EXAMINATI     | ON RE  | PORT   |

White - Doctor's Referral ١ Canary - File Date \_\_\_\_ \_\_\_\_\_ Grade \_\_\_\_ Birth Date\_\_\_\_\_ Name Sex Parent or Guardian Phone \_\_\_\_ Address County (Last) Testing Agency Tester \_\_\_\_ Testing Location TO BE COMPLETED FOLLOWING SCREENING REASON FOR REFERRAL TEST GIVEN 1. **U** Visual Acuity 1. Instrument Used \_\_\_\_ 2. Delus Sphere a. 🖵 Visual Acuity 3. U Muscle Balance – Phoria (First) b. 🖵 Plus Sphere 4. **U** Near and Far Binocular Vision – Fusion c. **D** Muscle Balance SYMPTOMS NOTED d. 📮 Near and Far Binocular Vision 1. **Academic Achievement** e. 🖵 Other: 2. 🖵 Observable Signs: TO THE DOCTOR CHILD WEARING GLASSES OR UNDER CARE Children wearing glasses or under care are not screened as part of the routine vision screening program. Observations by (Initial) screening technicians possibly indicate the following: Frames broken / too small Two years since last examination Lenses scratched / broken Other: TO BE COMPLETED BY EXAMINING DOCTOR DISTANCE PLEASE CHECK IF APPROPRIATE: UNCORRECTED BEST CORRECTED Treatment recommended (2) (1) VISUAL ACUITY VISUAL ACUITY Medical RIGHT LEFT RIGHT LEFT Glasses Contact Lenses Other: □ Corrective lens prescribed (3) Ocularmotor Assessment Constant Wear Near Vision only □ Far Vision only □ May be removed for physical education Diagnosis (4)Visual field restriction Amblyopia exists Comments \_\_\_\_\_ (5)□ Muscle imbalance exists Close work may be difficult or cause fatigue Preferential seating needed Re-examination advised Gix months IMPORTANT NOTICE Twelve months THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT Other: \_\_\_\_\_ IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 81-174. DISCLOSURE OF THIS INFORMATION IS VOLUN-TARY, AND THERE IS NO PENALTY FOR NON-COMPLIANCE. THIS FORM HAS Please print or stamp BEEN APPROVED BY THE FORMS MANAGEMENT CENTER. Doctors Name CONSENT OF PARENT OR GUARDIAN Address I agree to release the above information on my child or City \_\_\_\_ ward to appropriate school or health authorities. Date of Examination \_\_\_\_\_ PARENT OR GUARDIAN'S SIGNATURE