Illinois Department of Public Health
VISION EXAMINATION REPORT

Date ____________________
Name  ________________________________________________  Birth Date ________________________  Sex __________  Grade ____________
Parent or Guardian ________________________________________________________________________  Phone ____________________________
Address __________________________________________________________________________________  County ____________________________
Testing Location ______________________________  Testing Agency ____________________________________  Tester ______________________

TO BE COMPLETED FOLLOWING SCREENING

TEST GIVEN
1. Instrument Used ________________________________________
   a. ❏ Visual Acuity
   b. ❏ Plus Sphere
   c. ❏ Muscle Balance
   d. ❏ Near and Far Binocular Vision
   e. ❏ Other: ________________________________________

REASON FOR REFERRAL
1. ❏ Visual Acuity
2. ❏ Plus Sphere
3. ❏ Muscle Balance – Phoria
4. ❏ Near and Far Binocular Vision – Fusion

SYMPTOMS NOTED
1. ❏ Academic Achievement
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
screening technicians possibly indicate the following:
   ❏ Frames broken / too small
   ❏ Lenses scratched / broken
   ❏ Two years since last examination
   ❏ Other: ____________________________

TO BE COMPLETED BY EXAMINING DOCTOR

DISTANCE

<table>
<thead>
<tr>
<th>(1) UNCORRECTED</th>
<th>(2) BEST CORRECTED</th>
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</thead>
<tbody>
<tr>
<td>VISUAL ACUITY</td>
<td>VISUAL ACUITY</td>
</tr>
<tr>
<td>RIGHT</td>
<td>RIGHT</td>
</tr>
<tr>
<td>LEFT</td>
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(3) Ocularmotor Assessment ________________________________________

(4) Diagnosis ______________________________________________________

(5) Comments ______________________________________________________

PLEASE CHECK IF APPROPRIATE:

❑ Treatment recommended
  ❑ Medical
  ❑ Glasses
  ❑ Contact Lenses
  ❑ Other: ______________________________________________________

❑ Corrective lens prescribed
  ❑ Constant Wear
  ❑ Near Vision only
  ❑ Far Vision only
  ❑ May be removed for physical education

❑ Visual field restriction

❑ Amblyopia exists

❑ Muscle imbalance exists
  ❑ Close work may be difficult or cause fatigue

❑ Preferential seating needed

❑ Re-examination advised
  ❑ Six months
  ❑ Twelve months
  ❑ Other: ______________________________________________________

IMPORTANT NOTICE

THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT
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
BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

IDPH V-4   IL 482-0847   Revised 8-99

Please print or stamp

Doctors Name __________________________________________________

Address ________________________________________________________

City __________________________________________________________

Date of Examination ____________________________________________