State of Illinois
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 _____

Name (Last) (First) (Initial)

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

(1) UNCORRECTED VISUAL ACUITY		(2) BEST CORRECTED VISUAL ACUITY	
RIGHT	LEFT	RIGHT	LEFT

(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: _____

Please print or stamp

Doctors Name _____

Address _____

City _____

Date of Examination _____

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

_____
DOCTOR'S SIGNATURE