State of Illinois
Illinois Department of Public Health

VISION EXAMINATION REPORT

Name (Last) (First) (Initial)

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: _____

CHILD WEARING GLASSES OR UNDER CARE

TO THE DOCTOR ☐

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

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