

# Illinois Department of Public Health VISION EXAMINATION REPORT

Date: 6/8/2006

Name: [Redacted] DOB: 10/1/2002 Sex: M Grade: -1  
 Parent: [Redacted] Address: [Redacted] Hts., IL 60004 Home Phone: [Redacted]  
 Testing Agency: Cook County School District #23, Prospect Hts.  
 Tester: [Redacted]

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
- Two years since last examination
- Lenses scratched / broken
- Other: \_\_\_\_\_

### TO BE COMPLETED BY EXAMINING DOCTOR

**DISTANCE**

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

**PLEASE CHECK IF APPROPRIATE:**

- (3) Oculomotor Assessment \_\_\_\_\_
- (4) Diagnosis \_\_\_\_\_
- (5) Comments \_\_\_\_\_

- 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 VOLUNTARY, 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

Please print or stamp

Doctors Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Date of Examination \_\_\_\_\_

DOCTOR'S SIGNATURE