

“IMPORTANT INFORMATION”

- **The State of Illinois Certificate of Child Health Examination Form and State required immunizations are due before the first day of school.**

No Physical + No Immunizations = No First Day of School

- **Forms may be turned into the Health Office at Oakland until the end of the current school year. If you are unable to turn in before the school year ends, the Oakland office will open again at the beginning of August.**

We encourage you to have the forms completed as soon as possible and turn them in.

***Scheduled medical appointments after the first day of school are NOT acceptable in lieu of the required documentation.**



Oakland Main Office - 847-838-8601
Oakland Fax - 847-838-8604
Oakland Attendance Hotline - 847-838-8181
Oakland Health Office - 847-838-8611

If a student is transferring from another Illinois school their physical and immunizations must be received to complete the registration process. If transferring from a school outside the State of Illinois, a signed release of records is necessary to transfer the student's records to District 34. Parents will be notified if the health records are not in compliance with Illinois law and have 30 days to comply. Exclusion of a student for non-compliance is permitted.

We are pleased to welcome your student to Oakland. Here is some information from the health office that may be of some help during the school year.

FORMS

Health forms are on the District web site (antioch34.com) under "Departments" - "Health Services" - "Health Forms".

IMMUNIZATIONS

See the back of this pamphlet for immunizations required by the State of Illinois for entrance into Kindergarten thru 5th grade. Immunization dates should be filled in or attached to the front of the Child Health Examination Form by your physician. Religious Exemption Forms can be found on the district website or contact your school nurse regarding questions.

PHYSICAL EXAMINATIONS

Physical examinations are required by the State of Illinois for all students entering Kindergarten and 6th grade. For students entering 1st grade for the first time, students entering from other countries and students transferring from out of state, Exams must be dated within one year prior to the date of entering. Physicals and Immunizations are due before the first day of school. The Illinois Certificate of Child Health Examination form (Rev 11/20/15) is the only physical form that will be accepted. Students entering from out-of-state are allowed 30 days from the start date to be in compliance.

LEAD ASSESSMENT FORM

Lead screening is a State required part of the health examination for children six years or younger prior to admission to Kindergarten. Please make sure your physician completes the Lead Screening portion of the Child Health Examination.

VISION FORM

A vision examination is required by the State of Illinois for all children enrolling in Kindergarten and any child enrolling in an Illinois school for the first time or enrolling from out-of-state. The form is due October 15th of the current school year and must be completed by an Optometrist or Ophthalmologist.

DENTAL FORM

A dental examination is required by the State of Illinois for all students entering Kindergarten, 2nd and 6th grade. The Illinois Dental Examination Form is the only form that will be accepted. The form is due May 15th of the current school year. (Dated no more than 18 months prior to the May 15th deadline.)

Please contact the school nurse at 847-838-8611 with any questions or concerns you may have. If your student has a change in their medical status during the school year please keep the Health Office informed so your student can receive the best care possible.

ATTENDANCE

All absences must be reported to the office by 9:00 AM, and 12:00 PM for afternoon students. The telephone number is 847-838-8181. This is a 24-hour voice mail system for your use in reporting absences.

We also want to stress the importance of providing us with updated phone numbers. Please provide us with changes in phone numbers during the school year by calling the office. Vision screening will be conducted annually on students in 2nd and 8th grades; in all special education classes; all transfer students and student referred by teachers.

Hearing screening will be conducted annually on students in Kindergarten, 1st, 2nd and 3rd grades; in all special education classes; all transfer students and student referred by teachers.

MEDICATION

Only those medications that are necessary to maintain the child in school during school hours will be administered. All medications given in school, including prescription and OTC (non-prescription) medication shall be prescribed by a licensed prescriber on an individual basis as determined by the student's health status. Medication forms can be found on the District 34 websites or requested from the school nurse.

DO NOT SEND MEDICATION TO SCHOOL WITH YOUR STUDENT!

Medication must be brought to the Health Office by a parent/guardian, in the original container labeled appropriately by the pharmacist.

Prescription medication shall display:

1. Student's Name/Prescription Number
2. Name of Medication/Correct Dosage/Date Filled
3. Licensed Prescriber's Name
4. Non-prescription medications shall be brought in the original container with the student's name affixed to the container.
5. The "Physician's Certification and Authorization" portion of the form must be completed.
6. The "Parent Request and Authorization" portion of the form must be completed.
7. Changes in prescription medication will only be made when a note from the prescribing physician has been received.
8. The parent/guardian will be responsible for picking up any unused medication. Medication not picked up by the end of the school year will be destroyed.
9. In all cases, the school district retains the discretion to reject any request for administering medication in which case a parent/guardian can come to administer medication.
10. Medication orders must be renewed every school year.

PLEASE TAKE NOTE OF THE FOLLOWING HEALTH PRACTICES:

Students must be free from symptoms of fever (without the aid of a fever reducing medication), vomiting and diarrhea (without the aid of medication) for at least 24 hours before returning to school. A temperature of 100.4° or above is considered a fever.

Students exhibiting undiagnosed rashes will be sent home and excluded from school until the rash is cleared or a doctor's release to return to school is presented to the health office.

Students with conjunctivitis or "pink eye" may not return to school until the eyes are clear and without drainage or a doctor's release to return to school is presented to the health office.

District #34 requires a doctor's note after a prolonged absence (generally 3 or more days).

A physician's note must be provided releasing a student to return to school with a cast, splint, crutches or wheelchair, or from a recent surgery. A release from the physician is required to return to normal activity (ex: physical education, recess) after an activity restriction.

Weather permitting, all students will be sent outside at recess unless they have a note. Students are allowed to stay inside during recess for up to two days with a parent note, after two days a doctor's note must be on file in the health office. Students go outside when the temperature is 15 degrees or above, taking into account the wind chill.

Students are allowed to be excused from any school activity (PE, strings, etc.) for up to two days with a parent note, after two days a doctor's note must be on file in the health office.

*FOR FURTHER EXPLANATIONS REGARDING HEALTH POLICIES PLEASE REFER TO THE SCHOOL HANDBOOK ON THE DISTRICT 34 WEBSITE



Kindergarten Physical and Immunization Requirements

District 34 requires that the State of Illinois Certificate of Child Health Examination and all Immunizations required by the State of Illinois must be received before the first day of school in order for your student to avoid exclusion.

*Exclusion means that students who do not meet the above requirements will not be allowed to attend school until these requirements are met.

Note: Scheduled medical appointments are NOT acceptable in lieu of the required physical examination documentation.

- **Physical Examination**
 - Submit the State of Illinois Certificate of Child Health Examination Form.
The examination must be completed within one year of the first day of school.
 - **Immunization record** (front side) – completed and signed by licensed health care provider.
 - **Health History** (top back side) completed, signed, and dated by parent/guardian.
 - **Physical Examination** (lower portion of back side) completed and signed by licensed health care provider. **BMI, Diabetes Screening, and Lead Risk Questionnaire sections must be completed.**
- All required **Immunizations** must be up to date
 - Diphtheria, Tetanus, Pertussis- (DTP/DTaP) – 4 or more doses with last dose on or after the 4th birthday.
 - Polio - 4 or more doses of the same type of Polio with last dose on or after 4th birthday
 - Measles, Mumps, Rubella (MMR) - 2 doses with 1st dose given after 1st birthday and second dose no less than 4 weeks later.
 - Varicella (chicken pox) - 2 doses for student entering in Kindergarten or first grade. The 1st dose must have been received on or after the 1st birthday and the second no less than 4 weeks (28 days) later.
 - Hepatitis B - 3 doses
 - HIB - not required after 5th birthday (60 months of age)
- **Vision Examination**-Must be on the State of Illinois Eye Examination Report Form. It must be completed, signed and dated by an Ophthalmologist or Optometrist. The due date for this form is October 15.
- **Dental Examination** – Must be on the State Proof of Dental Examination Form. It is due by May 15 (dated no more than 18 months prior to the May 15 deadline) of the school year enrolled.

You may turn your Vision and Dental Examination Forms in with the above required paperwork (this is preferred).

All Forms and Immunization Schedule are available at: www.antioch34.com, ->Department->Health->Health Forms

Completed forms can be turned into the Health Office at Oakland until the end of the current school year. If you are unable to turn in before the school year ends, the Oakland office will open again at the beginning of August.

Last			First			Middle			Birth Date Month/Day/ Year			Sex	School	Grade Level/ ID
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER														
ALLERGIES (Food, drug, insect, other)			Yes No	List:			MEDICATION (Prescribed or taken on a regular basis)			Yes No	List:			
Diagnosis of asthma?			Yes	No				Loss of function of one of paired organs? (eye/ear/kidney/testicle)			Yes	No		
Child wakes during night coughing?			Yes	No				Hospitalizations? When? What for?			Yes	No		
Birth defects?			Yes	No				Surgery? (List all.) When? What for?			Yes	No		
Developmental delay?			Yes	No				Serious injury or illness?			Yes	No		
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes	No				TB skin test positive (past/present)?			Yes*	No	*If yes, refer to local health department.	
Diabetes?			Yes	No				TB disease (past or present)?			Yes*	No		
Head injury/Concussion/Passed out?			Yes	No				Tobacco use (type, frequency)?			Yes	No		
Seizures? What are they like?			Yes	No				Alcohol/Drug use?			Yes	No		
Heart problem/Shortness of breath?			Yes	No				Family history of sudden death before age 50? (Cause?)			Yes	No		
Heart murmur/High blood pressure?			Yes	No				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other						
Dizziness or chest pain with exercise?			Yes	No				Information may be shared with appropriate personnel for health and educational purposes.						
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____									Parent/Guardian Signature			Date		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)														
Ear/Hearing problems?			Yes	No										
Bone/Joint problem/injury/scoliosis?			Yes	No										
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI BMI PERCENTILE B/P														
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>														
LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.) Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date Result														
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm . No test needed <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____														
LAB TESTS (Recommended)		Date	Results						Date	Results				
Hemoglobin or Hematocrit						Sickle Cell (when indicated)								
Urinalysis						Developmental Screening Tool								
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs				Normal	Comments/Follow-up/Needs							
Skin						Endocrine								
Ears		Screening Result:				Gastrointestinal								
Eyes		Screening Result:				Genito-Urinary		LMP						
Nose						Neurological								
Throat						Musculoskeletal								
Mouth/Dental						Spinal Exam								
Cardiovascular/HTN						Nutritional status								
Respiratory		<input type="checkbox"/> Diagnosis of Asthma				Mental Health								
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)						Other								
NEEDS/MODIFICATIONS required in the school setting						DIETARY Needs/Restrictions								
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup														
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal														
EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.														
On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.) PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> INTERSCHOLASTIC SPORTS Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>														
Print Name		(MD,DO, APN, PA) Signature				Date								
Address						Phone								



State of Illinois Certificate of Child Health Examination

Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle		Month/Day/Year			
Address				Parent/Guardian			
Street City Zip Code				Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										Comments: * indicates invalid dose								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease Signature Title

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps** ☐Rubella ☐Varicella Attach copy of lab result.

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.

**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Illinois Department of Public Health
Childhood Lead Risk Assessment Questionnaire

**ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING
(410 ILCS 45/6.2)**

Name _____ Today's Date _____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	R E S P O N S E
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes No Don't Know
2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?	Yes No Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes No Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes No Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes No Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes No Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes No Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes No Don't Know
9. Does this child reside in a high-risk ZIP code area?	Yes No Don't Know

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**

- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result _____ mcg/dL Date _____ Test 2: Blood Lead Result _____ mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

Signature of Doctor/Nurse

Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466



PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City	ZIP Code	
Name of School:	ZIP Code	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Last Name	First Name		
Student's Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				

To be completed by dentist:

Date of Most Recent Examination: _____ (Check all services provided at this examination date)
☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc.

Appointment Date: _____

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

Appointment Date: _____

☐ **Pediatric Dentist Referral Recommended**

Treatment Completion Date: _____

Additional comments: _____

Signature of Dentist _____ License #: _____ Date: _____



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)
Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)
Parent or Guardian _____
(Last) (First)
Phone _____
(Area Code)
Address _____
(Number) (Street) (City) (ZIP Code)
County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____
Ocular history: ☐ Normal or Positive for _____
Medical history: ☐ Normal or Positive for _____
Drug allergies: ☐ NKDA or Allergic to _____
Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other _____



State of Illinois Eye Examination Report

Recommendations

1. Corrective lenses: ☐ No ☐ Yes, glasses or contacts should be worn for:
☐ Constant wear ☐ Near vision ☐ Far vision
☐ May be removed for physical education

2. Preferential seating recommended: ☐ No ☐ Yes

Comments _____

3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ 12 months
☐ Other _____

4. _____

5. _____

Print name _____

Optometrist or physician (such as an ophthalmologist)
who provided the eye examination ☐ MD ☐ OD ☐ DO

License Number _____

Address _____

Phone _____

Signature _____

Date _____

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)

(Date)

(Source: Amended at 32 Ill. Reg. _____, effective _____)