St. Nicholas of Tolentine School
3741 W. 62nd St.
Chicago, IL 60629
773-735-0772
"Where Students Flourish and Talents Flow"

Dear Parent,

The State of Illinois, Dept. of Health is requiring all Kindergarten Students to have an eye exam by October 15th.

Attached is the Eye Exam Form that must be filled out by the Optometrist and returned to school by August Information Pick Up Days.

Queridos Padres de Familia:

El Departamento de Salud del Estado de Illinois, está requiriendo que todos los Estudiantes en Kindergarden deberán tener el exámen de sus ojos para el 15 de octubre.

Adjunto encontrará la forma que deberá ser llenada por el oculista y regresarla a la escuela en Agosto cuando recoga su información de la inscripción.

Illinois
Eye Examination Report
(Approval Pending)

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15th 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 child beginning school.

Student Name: _____ Birth Date: _____ Sex: _____ Grade: _____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: _____ Phone: _____
(Last) (First) (Area Code)

Address: _____ County: _____
(Number) (Street) (City) (Zip Code)

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: ❑ None or Allergic to: _____
Other Information: _____

Examination

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity:	20 /	20 /	20 /	20 /
Best Corrected Visual Acuity:	20 /	20 /	20 /	20 /

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	❑	❑	❑	
Internal Exam (media, lens, fundus, etc.)	❑	❑	❑	
Neurological Integrity (pupils)	❑	❑	❑	
Binocular Function (stereopsis)	❑	❑	❑	
Accommodation and Vergence	❑	❑	❑	
Color Vision	❑	❑	❑	
IOP (glaucoma)	❑	❑	❑	
Oculomotor Assessment	❑	❑	❑	
Other: _____	❑	❑	❑	

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other: _____

Recommendations

1. Corrective Lenses: ❑ No ❑ Yes, glasses 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 Who Provides Eye Examinations

Address: _____

_____

Signature: _____
Optometrist or Physician Who Provides Eye Examinations

Phone: _____

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)