State of Illinois
Department of Public Health
Eye Examination Waiver Form

Please print:

Student Name _______________________________________________________________________ Birth Date_______________
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name __________________________________________________ Grade Level _________ Gender □ Male □ Female

Address _____________________________________________________________________________________________________
(Number) (Street) (City) (ZIP Code)

Phone ______________________________ (Area Code)

Parent or Guardian ____________________________________________________________________________________________
(Last) (First)

Address of Parent or Guardian ___________________________________________________________________________________
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

☐ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ALL KIDS.

☐ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

☐ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations:___________________

________________________________________________________________________________________________________

Signature __________________________________________ Date _______________________

(Source: Added at 32 Ill. Reg. _________, effective _____________)