

State of Illinois Department of Public Health Eye Examination Waiver Form

Please print:

Student Name					Birth Da	ite	
	(Last)		(First)	(Middle Initial)		(Mont	h/Day/Year)
School Name				Grade Level	Gender	□ Male	Give Female
Address							
	(Number)	(Street)		(City)		(ZIP Co	de)
Phone							
(Area Code)							
Parent or Guardian							
		(Last)		(First)			
Address of Parent or	Guardian						
		(Number)	(Street)	(City)		(Z)	IP 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 _____)