State of Illinois
Department of Public Health

EYE EXAMINATION WAIVER FORM

Please print:

<table>
<tr><td colspan="2">Student's Name: Last First Middle</td><td>Birth Date: (Month/Day/Year)</td></tr>
<tr><td colspan="2">Address: Street City ZIP Code</td><td>Telephone:</td></tr>
<tr><td>Name of School:</td><td>Grade Level:</td><td>Gender:
☐ Male ☐ Female</td></tr>
<tr><td>Parent or Guardian:</td><td colspan="2">Address (of parent/guardian):</td></tr>
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I am unable to obtain the required eye 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 a physician who provides eye examinations: ____

Signature ____ Date ____________________

(Source: Added at 33 Ill. Reg. ______, effective ____________)