



# 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 \_\_\_\_\_)