STATE OF ILLINOIS
Department of Human Services/Division of Rehabilitation Services
ILLINOIS SCHOOL FOR THE DEAF
125 Webster
Jacksonville, IL 62650

ADMISSIONS AND RECORDS OFFICE

Thank you for your interest in the Illinois School for the Deaf (ISD). Founded in 1839 and located on a beautiful 50-acre campus in Jacksonville, ISD is a state supported school for the education of children who are deaf and hard of hearing and is under the operation of the Department of Human Services, Division of Rehabilitation Services.

The educational program of the school is recognized by the Illinois State Board of Education and is accredited by AdvancED and the Conference of Educational Administrators of Schools and Programs for the Deaf. Comprehensive programming includes 0-3, preschool through eighth grade and high school. A college preparatory curriculum and an extensive career/technology program are offered in the high school. A student who has satisfied his/her graduation requirements from his/her home school district can elect to hold his/her diploma and enroll in ISD's Transitional Living Program.

Residential dormitories are available for students living 25 or more miles from ISD. Typically, there are two students to a room with 24 hour supervision provided by our residential care workers. There are approximately 210 students enrolled at ISD with 110 students living on campus. Children living in Jacksonville and surrounding communities may attend ISD as day students.

Enclosed please find a dvd showcasing what ISD offers students who are deaf and hard of hearing. Students have the opportunity to be involved in a variety of extracurricular activities and a full athletic program. ISD also maintains a teen center where students can gather for socializing. Many special events are planned through ISD's recreation department.

I am also enclosing a school calendar for the academic year. Students return home every weekend departing from campus every Friday either at 1:00 p.m. or 2:30 p.m. and returning every Sunday. Transportation is chaperoned by ISD residential care staff. Parents are required to bring their children to school on registration day in late August and pick them up on the last day of school in late May.

There is no tuition fee or charge for room and board; however, parents/guardians must meet the personal expenses of their child, including clothing, personal products, spending money, medical expenses, hearing aids and glasses. Illinois residency is a requirement as is a campus visit by the student and parent/guardian. ISD policy states that Deafness or Hard of Hearing must be listed as the student's primary disability on the Eligibility Review and the Illinois School for the Deaf must be listed as a placement option for education on the IEP. Please refer to the enclosed application documents for additional requirements and information.

We appreciate your interest in the Illinois School for the Deaf as you explore the educational options for your child. If I can be of further assistance or if you have questions regarding the admission process, please contact me at 217-479-4297 (V/TTY) or Carolyn.Eilering@illinois.gov .

Sincerely,

Carolyn Eilering, Director Admissions & Records

STATE OF ILLINOIS
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125 Webster
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APPLICATION INSTRUCTIONS

REQUIREMENTS WHEN APPLYING FOR ADMISSION

- **PARENT/LEGAL GUARDIAN REQUIRED TO:**
  - ❑Tour ISD campus with prospective student
    - ❑Interview with school principal
    - ❑Visit classroom and meet teacher
    - ❑Interview with social worker
    - ❑Visit dormitory and meet supervisor

- **PARENT/LEGAL GUARDIAN REQUIRED TO SEND:**
  - ❑Intake Application
  - ❑Information Sheet
  - ❑Copy of student's birth certificate
  - ❑Copy of student's social security card
  - ❑Student's IEP with ISD listed as a placement option for education
  - ❑Current Eligibility Review (ER) with reports
    - ❑Psychological Report
    - ❑Audiological Report
    - ❑Social Development Report
    - ❑Speech/Language Report
    - ❑Educational Report
    - ❑Other Reports (i.e., behavior management plan, mental health, medical, discipline)
  - ❑Achievement test scores
  - ❑Transcript (high school students only)
  - ❑Illinois Department of Public Health Certificate of Child Health Examination (school physical)
    - ❑Immunization Record
  - ❑Provide results of a **two-step** TB skin test that is less than one year old
  - ❑Dental Examination (only students in kindergarten, 2nd and 6th grades)
  - ❑Vision Examination (only students in kindergarten)

- **LETTER OF REFERRAL REQUESTING ENROLLMENT AT ISD:**
  - ❑ LEA/home school referral

    OR
  - ❑Parent direct referral

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Jacksonville, IL 62650

INTAKE APPLICATION

PLEASE PRINT Student Social Security Number ___-___-____

Student _____ _____ _____
first middle last

Date of Birth____/____/____ Place of Birth _____ ____ ☐Male ☐Female
City State

Ethnicity ☐White ☐African American ☐Hispanic/Mexican American ☐Asian ☐Other_____

Student's Primary Language ☐ASL ☐Spoken English ☐Spanish ☐Other_____

Primary Language in the Home ☐ASL ☐Spoken English ☐Spanish ☐Other_____

CUSTODIAL PARENT/GUARDIAN

Name_____ _____ Relationship_____
first last

Address_____ _____ ____ _____
street city state zip code

Phone ___-___-____-____ Occupation _____
cell home or work

Email Address_____ Date of Birth____/____/____

2nd PARENT/GUARDIAN

Name_____ _____ Relationship_____
first last

Address_____ _____ ____ _____
street city state zip code

Phone ___-___-____-____ Occupation _____
cell home or work

Email Address_____ Date of Birth____/____/____

Siblings _____ ____/____/____ _____ ____/____/____
name birthdate name birthdate

_____ ____/____/____ _____ ____/____/____
name birthdate name birthdate

If your child was not in special education what school would he/she attend?

Home School_____ District # _____County_____

Contact Person_____ Phone ___-___-____

Current School Attending_____Grade_____City_____

Primary Disability ☐Deaf ☐Hard of Hearing

Age of Diagnosis_____ Cause_____

Secondary Disabilities 1. _____

2._____

3._____

Reason I am applying for my child to enroll at the Illinois School for the Deaf _____

_____

_____

_____

_____

Student resides with ☐Mother ☐Father ☐Both ☐Other_____

I understand if my son/daughter enrolls in the Illinois School for the Deaf, I am responsible for his/her clothing, personal, and medical expenses. I request the loan of secular textbooks in accordance with section 18-17 of the School Code (IL Rev. Stat., 1995, ch. 122, par. 18-17) while my son/daughter is enrolled at the Illinois School for the Deaf. The Illinois School for the Deaf does not discriminate in admitting students of any race, sex, color, religion, national or ethnic origin.

PLEASE PRINT

Name _____

Relationship to Student _____

Date_____

STATE OF ILLINOIS
Department of Human Services/Division of Rehabilitation Services
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125 Webster
Jacksonville, IL 62650

INFORMATION SHEET

PLEASE PRINT **Student's Name** _____

HEALTH INFORMATION

1. Were there any complications at birth? ❑Yes ❑No
   If yes, please explain _____
2. Were developmental milestones on target? (i.e., sitting alone, walking, feeding self) ❑Yes ❑No
   If no, please explain _____
3. Does your child have difficulties going to bed on time? ❑Yes ❑No
4. Does your child wet the bed? ❑Yes ❑No
5. Does your child have food or environmental allergies? ❑Yes ❑No
   If yes, please explain _____
6. Does your child have choking tendencies? ❑Yes ❑No
7. What is child's overall general health? ❑Good ❑Average ❑Poor
8. Are there any past health concerns or past surgeries? ❑Yes ❑No
   If yes, please explain _____
9. Does your child take prescription medication? ❑Yes ❑No
   If yes, please list _____ _____ _____
10. Is your child allergic to any medications? ❑Yes ❑No
    If yes, please list _____ _____ _____
11. Does your child have any physical restrictions? ❑Yes ❑No
    If yes, please explain _____
12. Does your child wear prescription eye glasses? ❑Yes ❑No
    If yes, please explain _____
13. Does your child wear hearing aids? ❑Yes ❑No
    If yes, ❑left ear ❑right ear ❑both ears
14. Does your child have a cochlear implant? ❑Yes ❑No
    If yes, ❑left implant/year received _____ ❑right implant/year received _____

COMMUNICATION INFORMATION

15. Is your child fluent in American Sign Language? ❑Yes ❑No
16. What is your child's primary means of communication?
    ❑ASL ❑Spoken English ❑Gestures ❑Lip Reading ❑Note Writing ❑Other _____
17. What is the family's primary means of communication with the child?
    ❑ASL ❑Spoken English ❑Gestures ❑Note Writing ❑Other _____

BEHAVIOR INFORMATION

18. Does your child follow the rules at home? ❑Yes ❑No ❑Sometimes

    If no or sometimes, please explain _____

19. Does your child get along well with his/her siblings? ❑Yes ❑No ❑Sometimes

    If no or sometimes, please explain _____

20. Has there been a recent traumatic experience that has affected your child's behavior? ❑Yes ❑No

    If yes, ❑family illness ❑family death ❑divorce ❑physical abuse ❑sexual abuse ❑Other_____

21. Does your child enjoy school? ❑Yes ❑No ❑Sometimes

22. Does your child get along well with his/her classmates? ❑Yes ❑No ❑Sometimes

23. Does your child follow the rules at school? ❑Yes ❑No ❑Sometimes

24. Has your child ever been suspended from school? ❑Yes ❑No

    If yes, please explain reason_____

25. When your child becomes angry or frustrated does he/she use physical aggression? ❑Yes ❑No

26. What type of discipline works best with your child? ❑timeouts ❑taking away privileges

    ❑grounding ❑taking away items he/she enjoys ❑talking with him/her ❑Other_____

27. What does your child enjoy doing in his/her free time? _____

    _____

28. Name three of your child's personality strengths.

    1._____

    2._____

    3._____

29. Name three of your child's personality weaknesses.

    1._____

    2._____

    3._____

30. Are there any deaf family members? ❑Yes ❑No

    ❑mother ❑father ❑grandmother ❑grandfather ❑sister ❑brother ❑Other_____

PLEASE PRINT

Name_____

Relationship to Student_____

Date_____

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

DCFS

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)						
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

COMMENTS:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease	Signature	Title	Date

3. Laboratory confirmation (check one) ☐Measles ☐Mumps ☐Rubella ☐Hepatitis B ☐Varicella
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date												
Age/ Grade												
	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
Vision												
Hearing												

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Last	First	Middle	Birth Date (Month Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)

MEDICATION (List all prescribed or taken on a regular basis.)

Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No					
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell. Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ • Bridge ☐ • Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis?	Yes	No		**Parent/Guardian Signature**			**Date**

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐

Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ mm _____

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes		Amblyopia Yes☐ No☐	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** Yes ☐ No ☐ Limited ☐

Print Name (MD.DO. APN. PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)

EXAMPLE OF A PARENT DIRECT REFERRAL LETTER

Date

Carolyn Eilering, Director of Admissions and Records
Illinois School for the Deaf
125 Webster
Jacksonville, IL 62650

Dear Ms. Eilering:

In accordance with IL P.A. 86-1310, I, your name, parent of your child's name am making the direct referral for your child's name admission to the Illinois School for the Deaf.

Sincerely,

Parent Signature

STATE OF ILLINOIS
Illinois Department of Human Services/Division of Rehabilitation Services

ILLINOIS SCHOOL FOR THE DEAF

125 Webster
Jacksonville, IL 62650

2017 - 2018 Calendar

2017

Tuesday	**AUGUST**		High School Volleyball Girls Register
Thursday		17	Teacher Institute Day #1
Friday		18	Teacher Institute Day #2
Sunday		20	Student Registration Day
Monday		21	First Day of Classes
Friday	**SEPTEMBER**	1	Students Depart at 1:00pm (SIP #1 12:45 - 2:09pm)
Monday		4	No School - Labor Day Holiday
Tuesday		5	Students Return to Campus
Wednesday		6	Classes Resume
Friday/Saturday		15/16	Homecoming
Monday	**OCTOBER**	9	School in Attendance - Columbus Day Holiday
Friday		20	Students Depart at 1:00pm (Professional Development #1 12:45 - 3:00pm)
Friday	**NOVEMBER**	10	School in Attendance – Veterans' Day Holiday
Wednesday		22	Students Depart at 1:00pm (SIP #2 12:45 - 2:09pm)
Wednesday	**DECEMBER**	21	Students Depart at 1:00pm for Winter Break (SIP #3 12:45 - 2:09pm)

2018

Monday	**JANUARY**	1	No School - New Year's Day Holiday
Tuesday		2	Students Return to Campus (Teacher Institute Day #3)
Wednesday		3	Classes Resume
Monday		15	School in Attendance - Martin Luther King Holiday
Friday		19	Students Depart at 1:00pm (SIP #4 12:45 - 2:09pm)
Monday	**FEBRUARY**	12	School in Attendance - Lincoln's Birthday Holiday
Friday		16	Students Depart at 1:00pm (SIP #5 12:45 - 2:09pm)
Monday		19	School in Attendance – Presidents' Day Holiday
Thursday	**MARCH**	1	Students Depart at 1:00pm (Professional Development #2 12:45 - 3:00pm)
Friday		2	No School (Teacher Institute Day #4)
Wednesday		28	Students Depart at 1:00pm (SIP #6 12:45 - 2:09pm)
Thursday		29	No School (Snow Day #2)
Friday		30	No School (Snow Day #5)
Monday-Friday	**APRIL**	2 - 6	No School - Spring Break
Saturday	**MAY**	5	Prom
Wednesday		9	Students Depart at 2:30pm
Friday		10	No School (Snow Day #1)
Monday		11	No School (Snow Day #3)
Monday		14	Students return to campus (Snow Day #4)
Tuesday		15	Classes Resume
Thursday		24	Last Day of School – PreK-8 ASL Program – 8th Grade Promotion
Friday		25	High School Graduation

All Students depart ISD on Fridays at 2:30pm unless noted above and return to ISD on Sundays. Exceptions listed below.

- High School Students (9th-12th grades) Stay At ISD
  - September 15-16, 2017 (Homecoming)
  - November 17-18, 2017
  - May 4-5, 2018 (Prom)
- Non Sunday Return Dates
  - Tuesday, September 5, 2017
  - Tuesday, January 2, 2018
  - Monday, May 14, 2018
- Non Friday Depart Dates And Times
  - Wednesday, November 22, 2017, 1:00pm
  - Thursday, December 21, 2017, 1:00pm
  - Thursday, March 1, 2018, 1:00pm
  - Wednesday, March 28, 2018, 1:00pm
  - Wednesday, May 9, 2017, 2:30pm

- Snow Make Up Days If Needed in the following order
  - Thursday, May 10, 2018
  - Thursday, March 29, 2018
  - Friday, May 11, 2018
  - Monday, May 14, 2018
  - Friday, March 30, 2018

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle			Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code			Telephone:
Name of School:		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10 Printed by Authority of the State of Illinois

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 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 first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

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

County _____

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: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

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

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts 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 (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number _____

Address _____

_____

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)

_____

(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
6/09

IOC11271-09