Eye Examination Waiver Form Department of Public Health State of Illinois

Please print:

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

Birth Date_____(Month/Day/Year)

School Name _____ Grade Level _____ Gender: Male / Female

Address _____

Phone _____(Area Code)

Parent or Guardian _____(Last) _____ (First)

Address of Parent or Guardian _____

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 examinationsor 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/ALLKIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means anddo 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 _____)

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