State of Illinois
Department of Public Health

EYE EXAMINATION WAIVER FORM

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):	

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 _____)