State of Illinois  
Department of Public Health  
Eye Examination Waiver Form

Please print:

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

Birth Date ____________________ Sex _____ School ____________________________ Grade _______
(Month/Day/Year)

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 the free and reduced lunch program and is ineligible for public insurance (Medicaid/All KIDS).

My child is enrolled in Medicaid/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 see the child and accepts Medicaid/All KIDS.

My child does not have any type of medical or vision/eye care insurance coverage, and there are no low-cost vision/eye clinics in our community that will see my child.

Signature ____________________________ Date ____________________________

(Source: Added at 32 Ill. Reg. ________, effective _____________)

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