

**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: <input type="checkbox"/> Male <input type="checkbox"/> 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 \_\_\_\_\_)