PRESCHOOL
COMPREHENSIVE EYE AND VISION EXAMINATION REPORT

FOR ILLINOIS—Approved by the State of Illinois as proof of an eye examination.

Child's Last Name_____ **First Name**_____ **M.I.**___ **School Year**_____/_____

Address_____ **Date of Birth**____/____/____ **Age**____

Parent's Name_____ **Phone (**_____**)**_____

Name of Preschool/Day Care Facility_____

SUMMARY OF FINDINGS FOR THE PARENT AND TEACHER

CASE HISTORY/REASON FOR VISIT:_____

EYE HEALTH: Internal and external ocular health evaluation. ☐ **Normal** ☐ **Abnormal** GLAUCOMA: ☐ **Absent** ☐ **Present**

VISUAL ACUITY: A measure of the ability of the eyes to see well at both far and near distances.

	At Distance			**At Reading Distance_____inches**		
Without Correction:	R.Eye 20/	L.Eye 20/	Both 20/	R.Eye 20/	L.Eye 20/	Both 20/
With Best Correction:	R.Eye 20/	L.Eye 20/	Both 20/	R.Eye 20/	L.Eye 20/	Both 20/

REFRACTIVE EVALUATION: Measurements for eyeglass prescriptions including nearsightedness, farsightedness, and astigmatism.

☐ **No Refractive Error** ☐ **Nearsightedness (**Myopia) ☐ **Farsightedness** (Hyperopia**)** ☐ **Astigmatism** Comments_____

VISUAL EFFICIENCY: Functioning of the two eyes to enable comfortable, efficient visual performance at all distances.

1. DEPTH PERCEPTION: ☐ **Adequate** ☐ **Inadequate** Ability to use both eyes together to perceive and judge depth or relative distances.
2. MUSCLE IMBALANCE: ☐ **Absent** ☐ **Present** ☐ Near work may be difficult or cause fatigue. Comments_____
3. OCULOMOTOR EVALUATION: ☐ **Adequate** ☐ **Inadequate** Ability of the eyes to move accurately in all directions at an age appropriate level.
4. SUPPRESSION OF VISION: ☐ **Absent** ☐ **Present** A mental blocking by the brain of the image seen by an eye that does not function properly.
5. AMBLYOPIA: ☐ **None** ☐ **Right Eye** ☐ **Left Eye** A loss of vision. Comments_____
6. COLOR VISION: ☐ **Normal** ☐ **Deficient** Ability to distinguish colors accurately. Comments_____

DIAGNOSIS: ☐ **Normal** ☐ **Myopia** ☐ **Hyperopia** ☐ **Astigmatism** ☐ **Strabismus** ☐ **Amblyopia** ☐ **Muscle Imbalance**

☐ **Convergence Insufficiency** ☐ **Accommodative Dysfunction** ☐ **Oculomotor Deficiency** ☐ **Glaucoma** ☐ **Other**_____

☐ **No Treatment Indicated** ☐ **Treatment Recommended** ☐ Present Prescription Satisfactory ☐ New Prescription Ordered

☐ Contact Lenses Prescribed ☐ Vision Therapy ☐ Medical ☐ Other Comments_____

Glasses Should Be Worn: ☐ Constantly ☐ Near Vision ☐ Far Vision ☐ May be removed for Physical Education or Recess

CLASSROOM RECOMMENDATIONS: ☐ Preferential seating needed. Other comments:_____

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RE-EXAMINATION ADVISED: ☐ 6 Months ☐ 12 Months ☐ Other_____ Date of Examination_____

Signed_____ Diagnosis Code_____

Optometrist or Ophthalmologist O.D. M.D. D.O. (Circle One) License Number

Address_____ Phone (_____)_____

IMPORTANT NOTICE: Vision screening is *not a substitute* for a complete eye and vision evaluation by an eye doctor. A child is not required to undergo a vision screening if an optometrist or ophthalmologist completed and signed a report form indicating an examination had been administered within the previous 12 months. Requesting disclosure of this information is necessary to accomplish the statutory purpose as outlined under Illinois Public Acts 81-0174, 85-0351, 93-0504, and 95-0671. ***Consent of Parent:*** *I agree to release the above information on my child to appropriate school or health authorities.*

PARENT'S SIGNATURE:_____ **Date**_____