

PRESCHOOL COMPREHENSIVE EYE AND VISION EXAMINATION REPORT FOR ILLINOIS

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: _____

RE-EXAMINATION ADVISED: 6 Months 12 Months Other _____ Date of Examination _____

Signed _____ Diagnosis Code _____

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

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 and 93-0504. **Consent of Parent:** I agree to release the above information on my child to appropriate school or health authorities.

PARENT'S SIGNATURE: _____ Date _____