

# 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 \_\_\_\_\_

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