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: Stree	et	City	ZIP Code	Telephone:
Name of School:			Grade Level:	Gender:
				☐ Male ☐ Female
Parent or Guardian:			Address (of parent/guardian):	
I am unable to obtain	n the required vision exar	nination because:		
My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All KIDS).				
My shild is oprol	led in Mediceid/All KIDS b	ut we are unable to fine	l a madical dector who performs	ovo ovominations or an
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 that 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	