

State of Illinois Department of Public Health Eye Examination Waiver Form

Please print:

				Birth Date		
	(Last)	(Fin	rst)	(Middle Initial)	(Month/Day/Yea	r)
School Name			Grade	e Level G	Gender 🗆 Male 🗀 Fem	ale
Address						
	(Number)	(Street)		(City)	(ZIP Code)	
Phone)					
(Area Code))					
Parent or Guardian	1			(T)		
		(Last)		(First)		
Address of Parent	or Guardian	Number)	(Street)	(City)	(ZIP Code)	
or an optomet My child does	rist in the community v	who is able to examine			performs eye examinatio LL KIDS.	ns
do not have su	re no low-cost vision/endificient income to provourden or a lack of acce	ye clinics in our comn ride my child with an	nunity that will see meye examination.	y child, and I have exh	medical assistance/ALL austed all other means arons:	nd —