

State of Illinois Department of Public Health Eye Examination Waiver Form

rie	ease print:						
Student Name			(Middle Initial) Birth Date (Month/Day/Year				
	(Last)	(First)	(Midd	lle Initial)		(Mont	∆/Day/Year)
Scl	nool Name		Grade Level _		Gender	□ Male	☐ Female
Address (Number) (Street)			(City)		(ZIP Code)		
	(/	` ,	(City)			(ZIF CO	16)
Pho	(Area Code)	· .					
Par	rent or Guardian	7		(First)			
		(Last)		(LII21)	• .		
Ad	dress of Parent or Guardian		(Street)	(Cita)			IP Code)
		(Number)	(Street)	(City)		(Δ	ir Code)
т.	m unable to obtain the required	vicion avamination because:	•		•		
۵	or an optometrist in the commun. My child does not have any type KIDS, there are no low-cost visit do not have sufficient income to	of medical or vision/eye care on/eye clinics in our communi	coverage, my child does not ty that will see my child,	not qualify :	for medic	al assistar	
	Other undue burden or a lack of	access to an optometrist or to	a physician who provides	eye examin	ations:		
Sig	gnature		Date	· · · · · · · · · · · · · · · · · · ·			
	: (Sourc	e: Added at 32 III. Reg.	, effective)	