**Section 665.APPENDIX C Illinois Department of Public Health Eye Examination Waiver Form**

**State of Illinois**

**Department of Public Health**

**EYE EXAMINATION WAIVER FORM**

**Please print:**

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| --- | --- |
| Student's Name: Last First Middle | Birth Date: (Month/Day/Year) |
| Address: Street City ZIP Code | Telephone: |
| Name of School: | Grade Level: | Gender: [ ]  Male [ ]  Female |
| Parent or Guardian: | Address (of parent/guardian): |

**I am unable to obtain the required eye examination because:**

❑ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ALL KIDS.

❑ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

❑ Other undue burden or a lack of access to an optometrist or a physician who provides eye

|  |  |
| --- | --- |
| examinations: |  |

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| Signature |  | Date |  |

(Source: Added at 33 Ill. Reg. 8459, effective June 8, 2009)