



State of Illinois
Department of Public Health
Eye Examination Waiver Form

7:100 E

Please print:

Student Name (Last) (First) (Middle Initial) Birth Date (Month/Day/Year)

School Name Grade Level Gender Male Female

Address (Number) (Street) (City) (ZIP Code)

Phone (Area Code)

Parent or Guardian (Last) (First)

Address of Parent or Guardian (Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision 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 to a physician who provides eye examinations:

Signature Date

(Source: Added at 32 Ill. Reg. , effective )

Approved: June 24, 2009