State of Illinois
Department of Public Health
Eye Examination Waiver Form

R16

Please print:

Student Name ______________________________ Birth Date __________
(Last) (First) (Middle Initial) (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: ____________________

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Signature ______________________________ Date ____________________

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

For use in 2019-20

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