

## State of Illinois Department of Public Health Eye Examination Waiver Form

Please print: Student Name \_\_\_ (Last) (First) (Middle Initial) School Sex Grade Birth Date \_\_\_ Address \_\_\_\_\_ (Number) (Street) (City) (ZIP Code) Phone (Area Code) Parent or Guardian (Last) Address of Parent or Guardian (ZIP Code) (Street) (City)

## I am unable to obtain the required vision examination because:

My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All KIDS).

My child is enrolled in Medicaid/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 see the child and accepts Medicaid/All KIDS.

My child does not have any type of medical or vision/eye care insurance coverage, and there are no low-cost vision/eye clinics in our community that will see my child.

Signature		Date	Date	
	(Source: Ad	lded at 32 III. Reg	effective	)