

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

## Please print:

Stı	ident Name					Birth Date	
	(La	st)	(First)	(Middle Initial)		(Month/Day/Year)	
Scl	hool Name		G:	rade Level	_ Gender 🛘	Male    Female	
Ad	ldress						
	dress(Number)	(Street)		(City)		(ZIP Code)	
Ph	(Area Code)	<del> </del>					
	(Area Code)						
Pa	rent or Guardian						
		(Last)		(First)			
Ad	dress of Parent or Guardian	(Nyambou)	(Street)	(City)		(ZIP Code)	
		(Number)	(Sifeet)	(City)		(ZIP Code)	
	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:						
Sig	gnature		Date				
	(S	ource: Added at 32 II	ll. Reg,	effective	)		