# ILLINOIS DEPARTMENT OF PUBLIC HEALTH
# VISION CONSERVATION ANNUAL REPORT
# INSTRUCTIONS FOR COMPLETING FORM (IDPH/ V-3)

## SCREENING

**Enter all screening data by preschool, in line a, and by school age, in lines b-o. All full-time special education class children must be entered on line o.**

Column

1. NUMBER SCREENED. Enter the total number of children instrument screened. (Do not enter children wearing glasses in this column.)

2. NUMBER RESCREENED. Enter the total number of children rescreened.

3. NUMBER REFERRED. Enter the total number of children who met referral criteria following rescreening and/or were referred because of observable symptoms.

4. NUMBER WITH GLASSES. Enter the total number of children in the groups you screened who were wearing glasses.

5. GLASSES REFERRAL. Enter the number of children wearing glasses who were referred.

**Sum data entered in each column, 1 through 5, and enter these sums on line p.**

## FOLLOW-UP RESULTS

**Enter all follow-up results by school-age, in column 6, and preschool, in column 7.**

Number of Completed Medical Referrals (q). Enter total number of children for whom a vision examination report has been returned or information obtained verifying examination and diagnosis. Do not include glasses referrals.

Number of Referrals Not Completed (r). Enter the total number of children for whom no report has been received or information obtained verifying an examination and diagnosis.

**Sum lines q, r and s, and columns 6, 7 and 8. The sums of column 8 and line s must be equal. The number entered in cell 8-s must equal the total number of children referred, cell 3-p.**

## DIAGNOSIS

**Enter all diagnostic data by school age, in column 6, and preschool, in column 7.**

Total Number of Children Found To Have. Enter the total number of children with a diagnosis on the following lines:

A. REFRACTIVE ERRORS
   1. Myopia (t)
   2. Hyperopia (u)
   3. Astigmatism (v)
   4. Other (w)

B. MUSCLE BALANCE (x)

C. AMBLYOPIA (y)

D. PATHOLOGY (z)

E. COMBINATIONS OF FINDINGS (aa)

F. NORMAL (bb)

**Sum lines t through cc and columns 6, 7 and 8. The sums of 8-q and 8-cc must be equal. The number entered in cell 8-cc must equal the number of completed referrals, cell 8-q.**

NUMBER REFERRED TO SPECIAL EDUCATION (dd). Enter the total number of children who met educational referral criteria.

COLOR (ee). Enter the total number of children screened for color and the total number who failed the screening.

## PROGRAM

Print or type agency name, i.e. school district name and number, health department name or other agency name. Print or type agency address: number and street, city, ZIP code and county. Enter the name and telephone number of the individual submitting the report. Enter the date the report is submitted.

**Submit one cumulative annual report from each school district, health department or other agency responsible for vision screening. Submit this report to the Department's Vision and Hearing Program by June 30 of each year.**

**PLEASE TYPE OR PRINT LEGIBLY. CHECK ALL COMPUTATIONS. THIS FORM IS USED TO COMPILE STATEWIDE STATISTICS. THANK YOU FOR YOUR COOPERATION.**

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH ASSESSMENT AND SCREENING

# VISION CONSERVATION ANNUAL REPORT
## JULY 1, _____ TO JUNE 30, _____

| | 1 Number Screened | 2 Number Rescreened | 3 Number Referred | 4 Number of Children with Glasses | 5 Glasses Referral |
|---|---|---|---|---|---|
| Preschool a | | | | | |
| K b | | | | | |
| 1 c | | | | | |
| 2 d | | | | | |
| 3 e | | | | | |
| 4 f | | | | | |
| 5 g | | | | | |
| 6 h | | | | | |
| 7 i | | | | | |
| 8 j | | | | | |
| 9 k | | | | | |
| 10 l | | | | | |
| 11 m | | | | | |
| 12 n | | | | | |
| Sp.Ed o | | | | | |
| TOTAL p | | | | | |

NUMBER REFERRED TO SPECIAL EDUCATION(dd) _____
COLOR(ee) SCREENED _____ COLOR FAILED _____

**Submit by June 30 to**

**Fax 217-524-4201** **or** **IDPH Vision and Hearing**
**535 W. Jefferson St., Third Floor**
**Springfield, IL 62761**

| FOLLOW-UP RESULTS | 6 School -age | 7 Pre-school | 8 Total |
|---|---|---|---|
| Number of completed referrals .....q | | | |
| Number of referrals not completed ……..r | | | |
| Total ……...……..s | | | |
| **DIAGNOSIS** | | | |
| Total number of children found to have | | | |
| A. Refractive errors…….. | | | |
| 1. Myopia ……..……t | | | |
| 2. Hyperopia……u | | | |
| 3. Astigmatism……..v | | | |
| 4. Other……w | | | |
| B. Muscle balance……...x | | | |
| C. Amblyopia……...y | | | |
| D. Pathology…….....……z | | | |
| E. Combinations of findings….……aa | | | |
| F. Normal ……..bb | | | |
| TOTAL……cc | | | |

**PROGRAM**

| | |
|---|---|
| Name | Dist.# |
| Address | |
| City | ZIP Code |
| County | Phone Number |
| Submitted By | Date |
| E-mail Address | |

SUBMIT ONE ANNUAL SUMMARY FOR VISION PER SCHOOL DISTRICT (OR HEALTH DEPARTMENT PER COUNTY).