State of Illinois
Illinois Department of Public Health

VISION CONSERVATION ANNUAL REPORT
INSTRUCTIONS FOR COMPLETING FORM

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.

Add the 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). EEnter 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.

Add 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.

VISION CONSERVATION ANNUAL REPORT
INSTRUCTIONS FOR COMPLETING FORM

DIAGNOSIS

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

Add 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 Illinois Department of Public Health's Vision and Hearing Program by June 30 of each year.

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

IOCI 27-58 IOCI GRAPHICS

State of Illinois
Illinois Department of Public Health

VISION CONSERVATION ANNUAL REPORT

JULY 1, _____ TO JUNE 30, _____

This document contains preliminary information.

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

NUMBER REFERRED TO SPECIAL EDUCATION(dd) _____

COLOR(ee) SCREENED _____ COLOR FAILED_____

Report due by June 30
Utah State University STRATA Program
NCHAM/HI TRACK Help Desk
ncham.helpdesk@usu.edu or Phone 435-797-3584
Email contact is preferred
Hours - Monday - Friday 8:00 am - 5:30 pm (MST)

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

Program Name	Dist.#
Address	
City	ZIP Code
County	
Submitted By	
Phone Number (of submitter)	Date
E-mail Address	

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

IOCI 27-58 IOCI GRAPHICS