

**Shelby County Public Health Department**  
**Vision And Hearing Fee Form**  
**1700 W.S. Third Street**  
**Shelbyville, IL 62565**  
**Phone: (217)774-9555**  
**2018-2019**

In accordance with the "Child, Vision, and Hearing Test Act" of Illinois, each child in Grades K, 1, 2, 3, 5, and 8 are screened for Vision and Hearing. The fee for each both screenings is \$8.00. If your child already wears glasses or contacts, they do not need a vision test. All fees are non-refundable. Please complete the form below for each child of yours who is in the mandated grade. (YOU MAY PAY WITH CASH OR A CHECK MADE OUT TO THE HEALTH DEPARTMENT.) If you have a Public Aid medical card, please write each child's Medicaid number below.

Child's Name: Last _____ First _____ Circle Grade: K 1 2 3 5 8 Medicaid Number _____ Does child already wear glasses or contacts? Yes _____ No _____
Child's Name: Last _____ First _____ Circle Grade: K 1 2 3 5 8 Medicaid Number _____ Does child already wear glasses or contacts? Yes _____ No _____
Child's Name: Last _____ First _____ Circle Grade: K 1 2 3 5 8 Medicaid Number _____ Does child already wear glasses or contacts? Yes _____ No _____

I hereby give permission for my child (children) to receive a hearing and/or vision screen Parent/Legal Guardian Signature: \_\_\_\_\_

\_\_\_\_\_ Total Amt. Pd. \_\_\_\_\_/or Medicaid #  
 Today's Date                      Check                      Cash                      Hearing / Vision Screen \$8.00 per child

School District: \_\_\_\_\_