Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible

Vision Services Consent, Release of Liability, and Authorization Form

Please Print: Parent Email Address _____

Student Name: _____ Student's Date of Birth_____ ☐ Male ☐ Female

School Name: _____Student ID# _____Grade: _____Room# _____

Parent/Guardian Name: _____Home Address: _____Phone: _____

Medicaid/Medical Card/ALLKids recipient #_____ Race/Ethnicity_____

Private Vision Insurance: _____Group ID_____ ID#_____ Cardholder Name:_____ Birth Date_____

Private Medical Insurance: _____ Group ID _____ ID# _____ Cardholder Name: _____

As the parent/guardian of the above name student, I understand that my child will receive a comprehensive eye exam to determine if he/she needs prescription glasses or other treatment by a vision care professional (Provider)

I further understand that this eye exam may be performed by an Optometrist; an Ophthalmologist; qualified specialist; or an intern, a resident, or a student clinician or technician under the supervision of an Optometrist, Ophthalmologist, or another qualified specialist, and I consent to have my child receive a vision exam and/or treatment.

I further understand that neither the school nor the Board of Education of the City of Chicago (Board) are supervising or overseeing any services (such as an eye exam) or materials (such as eye glasses) that may be furnished to my child and that the Board and the school will have no responsibility for the quality of any such services or materials.

In consideration for the services and materials that my child will receive, I hereby agree to indemnify, release and hold harmless, and defend the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, and representatives, and the Board and its members, trustees, agents, officers, contractors, volunteers, representatives, and employees from any liability which may accrue to me or my child, for any and all claims, losses, injuries, damages to me or my child, both known and unknown, foreseen and unforeseen, arising in connection with my child's receipt of services and materials, whether or not said claims, losses, injuries, damages, or liabilities result in whole or in part from the negligence of the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the Board, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives. I further agree to release and hold harmless the Providers and Co-Sponsors, their employees, officers, volunteers, agents and representatives from and against any and all claims, demands, actions, complaints, suits or other forms of liability that will arise out of or by reason of, or be caused by any performance of services provided by such Providers or the quality of the eyeglasses or any other materials furnished by them under the Program, unless attributed to their willful or wanton misconduct. In the event that one provision of this form is held unenforceable, that provision shall be severed and the remainder of the form shall remain in effect.

I understand that the Provider will bill any government or private insurance Illinois Department of Healthcare and Family Services (HFS) or any other currently applicable private insurance for any reimbursable services and/or materials.

If you DO NOT want your child to receive the following services, please check the appropriate box. Please note services will be performed unless indicated otherwise.

If your child has an allergy, please consult your primary care physician before selecting dilation

I understand that as part of this eye exam, pharmaceutical agents (eye drops) will be used for the purpose of dilating my child's eyes. These drops are an important part of an eye exam to allow the Provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops include blurred vision and sensitivity to light, both of which could restrict my child's mobility making it unsafe for him/her to travel unassisted or to operate a vehicle for the rest of the day.

☐ **At this time I DO NOT consent for my child's eyes to be dilated**

I understand that by refusing dilation I may limit the doctor's ability to detect and treat certain conditions.

I understand that my child may be selected to be photographed, video taped, audio taped or interviewed as part of promotional documentation for the Vision Program. I consent to the use of my child's photograph, voice or likeness by the Board or the Provider or CDPH, but not the use of my child's last name. I understand there is no compensation, monies, or reimbursement for my child's participation.

☐ **At this time I DO NOT consent for my child to be photographed or interviewed**

By signing below, I understand that I am giving my authorization to the City of Chicago Department of Public Health (CDPH) and the Board of Education of the City of Chicago (Board) to release and furnish information regarding past vision screening data in my child's education record to Providers to ensure that the Providers can effectively provide services. I authorize the Providers to release and furnish reports to my child's school, including written and verbal reports concerning the results of any eye exam, for inclusion in my child's education record. I also authorize CDPH to release to the Board, my child's information, the date and type of vision services provided, whether my child was recommend for follow-up services, and other information the State of Illinois requests the Board to report. I understand that such records will be subject to the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinois Department of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization.

This authorization is valid for one year. I may revoke this authorization at any time by sending written notification to CDPH, my child's school, or the Board Office of Student Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

*****Please sign and date both signature lines. Complete the medical history on reverse side of this form.*****

Parent/Guardian Signature:_____**Date:**_____

I hereby give my consent for this child to be examined by a Provider for an eye exam and prescription eyeglasses, if prescribed during the eye exam. This consent does not authorize any treatments or service beyond what is stated. I understand my consent will be valid for one year from the date of signature.

Parent/Guardian Signature: _____ **Date:**_____

Must have the original signature, an electronic signature is not acceptable

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Student Medical History Form

Please Print:
Student's Name:_____ School Name: _____

Student's Date of last Eye Exam: _____ Does your child currently wear glasses or contacts? ☐ Yes ☐ No
How did you find out about the Vision Program? (Check all that apply)
School staff Failed Vision Screening Letter Friend Other_____

Does your child have any of the following conditions: (Check all that apply)

☐ Asthma	☐ Behavioral problems	☐ Attention Deficit Disorder	☐ Glaucoma
☐ Neurological problems	☐ Endocrine problems	☐ High Blood Pressure	☐ Musculoskeletal problems
☐ Heart Disease	☐ Mental Health illness	☐ Gastrointestinal problems	☐ Genitourinary problems
☐ Hearing/Ear problems	☐ Diabetes	☐ Other Condition	_____

Is your child taking any medications? ☐No ☐Yes
List medications:

_____

_____

Does your child have allergies? ☐No ☐Yes
List allergies:

_____

_____

Does your child use eye drops? ☐No ☐Yes
List eye drops:

_____

_____

Has your child ever had eye surgery? ☐No ☐Yes
If yes, please explain:

_____

_____

Has s/he had any of the following?

Vision Therapy	☐ No	☐Yes	Eye Injury	☐ No	☐ Yes	Trouble finishing work	☐ No	☐ Yes
Eye patch	☐ No	☐ Yes	Eye Infection	☐ No	☐ Yes	Lack of confidence	☐ No	☐ Yes
Eye Surgery	☐ No	☐ Yes	Itching/Burning	☐ No	☐ Yes	Difficulty sitting still	☐ No	☐ Yes
Pain in eyes	☐ No	☐ Yes	Eye Discharge	☐ No	☐ Yes	Avoids reading/writing	☐ No	☐ Yes
Difficulty Tracking	☐ No	☐ Yes	Tearing/Watering	☐ No	☐ Yes	Difficulty paying attention	☐ No	☐ Yes
Lazy/Wandering Eye	☐ No	☐ Yes	Light sensitivity	☐No	☐ Yes	Reads below grade level	☐ No	☐ Yes
Blurred/Double Vision	☐ No	☐ Yes	Redness	☐ No	☐ Yes	Poor handwriting	☐ No	☐ Yes
Loses place while reading	☐ No	☐ Yes	Drooping Lid	☐ No	☐ Yes	Frustrates easily	☐ No	☐ Yes

Other_____

Does your child have an IEP (Individualized Education Plan)? ☐ No ☐ Yes

Is the child performing at: ☐ above grade level ☐ grade level ☐ below grade level

If below grade level, please select the class (Check all that apply)
☐ Reading ☐ Writing ☐ Math ☐ Social Studies ☐ Other_____

Is the child currently receiving any of the **services** below? (Check all that apply)
☐ Special Education ☐ Tutoring ☐ Speech Therapy ☐ Occupational Therapy (OT) ☐ Physical Therapy (PT)

List any of your child's Hobbies or Special Interests: _____

Is there anything else you would like us to know about your child? _____

Does your child's immediate family member have any of the following? (Check all that apply and the relationship to child)

☐ Wears glasses	☐ Wandering Eye	☐ Diabetes	☐ Cardiovascular problems
☐ Glaucoma	☐ Blindness	☐ Musculoskeletal problems	☐ Neurological problems
☐ Lazy eye	☐ Macular Degeneration	☐ Heart Disease	☐ Mental Health illness
☐ High Blood Pressure			