

Dear Parent/Guardian,

Good vision is essential for success in school. We are pleased to announce that the Chicago Public Schools (CPS) Vision Program will be serving your school this year! CPS provides access to vision exams for students so that they may succeed in school.

The CPS Vision Program provides eye exams and glasses (if needed) at **NO COST** to the student. If the student does not have insurance, the vision exam and eyeglasses are provided at no cost to the family. If available, health insurance will be billed.

Below are signs that indicate your child may benefit from an eye exam:

- ☐ My child is entering kindergarten
- My child is entering Illinois schools for the first time at any grade level
- ☐ My child failed the vision screening
- ☐ My child has an IEP
- My child's teacher recommended they receive an eye exam
- My child experiences any of the following:
 - Squinting
 - Tilting the head
 - Sitting too close to the television
 - Losing place while reading
 - Rubbing eyes
 - Excessive tearing or headaches

Complete the consent form by:

- 1. Signing the two signature lines.
- 2. Completing the last page with your child's medical history.
- 3. Returning the form to your child's school **as soon as possible** Your child will not be able to participate without a signed consent form.

Following the eye exam, if your child requires glasses, an optician will assist your child with selecting the frame. Glasses will be delivered within 4-5 weeks to the school.

If you do not want your child to participate in the program, you do not need to complete or return the form to the school. However, if your child received an eye exam from an eye doctor outside of the CPS Vision Program please ensure your child's health records are up to date by having the doctor complete the State of Illinois Eye Examination Report found here: http://cps.edu/OSHW/Documents/VisionExaminationForm.pdf

If you have questions, please contact Katheryn Stafford-Hudson at 773-535-8675, or via email at kgstaffordh@cps.edu

Sincerely,

Kenneth G. Papineau

Manager



Estimado padre/tutor legal,

Una buena visión es esencial para el éxito en la escuela. ¡Tenemos el placer de anunciar que el Programa de Visión de las Escuelas Públicas de Chicago (CPS) servirá su escuela este año! CPS ofrece acceso a exámenes de la vista a sus estudiantes, para que puedan ser exitosos en la escuela.

El programa ofrece exámenes y anteojos (si son necesarios) **SIN COSTO ALGUNO** para el estudiante. Si este no tiene seguro médico, el examen y los anteojos son provistos sin costo para la familia. Si está disponible, se le enviará la cuenta al seguro médico.

Estos son las señales que indican que su niño puede beneficiarse con un examen de la vista:

Mi niño está ingresando en el jardín	M
infantil	si

- Mi niño ingresa en una escuela de Illinois por primera vez, en cualquier nivel de grado
- ☐ Mi niño falló en la prueba de visión
- ☐ Mi niño tiene un IEP
- ☐ El maestro de mi niño recomendó que se le hiciera el examen

- Mi niño experimenta cualquiera de lo siguiente:
 - Entrecierra los ojos
 - Inclina la cabeza
 - Se sienta muy cerca del televisor
 - Se confunde al leer
 - Se resfriega los ojos
 - Lagrimeo excesivo o dolores de cabeza

Complete el formulario de consentimiento:

- 1. Firmando en las dos líneas provistas al respecto.
- 2. Complete la última página con el historial médico del niño.
- 3. Devuelva el formulario a la escuela del niño **lo más rápido posible –** Su niño no podrá participar sin un formulario de consentimiento firmado.

Después del examen de la vista, si el niño necesita anteojos, un óptico lo ayudará a escoger el armazón. Los anteojos serán entregados en la escuela en un plazo de 4 a 5 semanas.

Si usted no quiere que su hijo participe en el programa, no tiene que llenar o devolver el formulario a la escuela. Sin embargo, si su niño fue examinado por un oculista fuera del Programa de Visión de CPS, por favor asegúrese que los registros estén actualizados, y haga que el médico complete el Reporte de Examen de la Vista del Estado de Illinois, que se puede encontrar aquí:

http://cps.edu/OSHW/Documents/VisionExaminationForm.pdf

Si tiene alguna pregunta, contacte por favor a Katheryn Stafford-Hudson por el 773-535-8675, o por correo electrónico a kgstaffordh@cps.edu

Atentamente,

Kenneth G. Papineau

Administrador



Parent/Guardian Signature:_

Vision Services Consent, Release of Liability, and Authorization Form

Student Name: Student iD# Grade: Room# rent/GuardianName: Home Address: Phone: edicaid/ALLKids recipient # Race/Ethnicity. ther Insurance: Group ID ID# Cardholder Name: Birth Date Birth Date the parent/guardian of the above name student, I understand that my child failed a vision screening test performed at school, or was recommended for a comprehensive exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional (Provider). Inderstand 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 eye exam to allow the Provider to conduct a thorough eye health exam. I further understand that the imporary effects of these eye drops may include blurred vision an astivity 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. I furthe derstand that this eye exam may be performed by an Optometrist, an Opthalmologist, qualified specialist, or an intern, a resident, or a student clinician or technicia der the supervision of an Optometrist, Ophthalmologist, or another qualified specialist, and I consent to have my child receive the above exam and/or treatment. I consent all of the following services unless the boxes below are checked "no." unterior 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) of aterials (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 of aterials. 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, it partitions, exployees, officers, contractors, volunteers, agents, officers, contractors, volunteers, agents, or presenta		Consent, Release of Liability, and Authorization Form						
rente GuardianName: Home Address: Race/Ethnicity her Insurance: Group ID ID# Cardholder Name: Birth Date the parent/guardian of the above name student, I understand that my child failed a vision screening test performed at school, or was recommended for a comprehensive exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional (Provider). nderstand that as part of this sye exam, pharmaceutical agents (eye drops) will be used for the purpose of dilating my child's eyes. These drops are an important part or give exam to allow the Provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops may include blurred vision an stirivity 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. I further understand that this yee exam may be performed by an Optometrist, an Optometrist, and the production of an Optometrist, ophthalmologist, qualitied specialist; on a intern, a resident or testing of the special care in the production of an Optometrist, Ophthalmologist, qualitied specialist; or a intern, a resident or testing and the following services unless the boxes below are checked 'no. unther 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) and or the services and materials that my child will receive, I hereby agree to indemnify, release and hold harmless, and defend the City of Chicago, in particular that the services and materials that my child will receive, I hereby agree to indemnify, release and hold harmless, and defend the City of Chicago, in particular that the providers of the particular to the contractors, volunteers, agents, and representatives, and the Board and its members, trustees, agents, officers, contractors, volunteers, agents, and representatives, and the Board and its members, trustees, ag	Please Print: Student Name:		Student's Date					
her Insurance: Group ID ID# Cardholder Name: Birth Date Like parent/guardian of the above name student, I understand that my child failed a vision screening test performed at school, or was recommended for a comprehensive exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional (Provider). Inderstand that as part of this eye exam, pharmaceutical agents (eye drops) will be used for the purpose of diluting my child's eyes. These drops are an important part of eye exam to allow the Provider to conduct a thorough eye health exam. Intrinse understand that the temporary effects of these eye drops may include blurned vision an attention of the provider to conduct a thorough eye health exam. I turn the understand that the temporary effects of these eye drops may include blurned vision and stricted blurb of the conduction of the provider o	School Name:		Student ID#		Grade:	Room#		
the parent/guardian of the above name student, I understand that my child failed a vision screening test performed at school, or was recommended for a comprehensive exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional (Provider). In the parent/guardian of the above name student, I understand that my child see and of the exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional (Provider). In the control of the provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops may include blurred vision an activity to light, bolt of which could restriction up fulled smobility in adding to understand that the temporary effects of these eye drops may include blurred vision and studying to light be with the condition of the control of the provider to operate a velocite for the east of the day. I further understand that the control of the control of the day to another qualified specialist, and I consent to have my child receive the above exam and/or treatment. I consent all of the following services unless the boxes below are checked "no." unther understand that neither the school nor the Board of Education of the City of Chicago (Board) are supervising or overseeing any services (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 of nerials. 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, it partments, employees, officers, contractors, volunteers agents, and employees from any liability which may accrue to me or my child, for any and all claims, losses, injuites, dended the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives, and employees from any liability which may accrue to me or my child, for	Parent/GuardianName: Medicaid/ALLKids recipient #		Home Address:	Race/Ethnicity		Phone:		
anderstand 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 or eye exam to allow the Provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops may include blurred vision an stirivity to light, both of which could restrict my child's mobility making it unaste for him/her to travel unassisted or to operate a vehicle for the rest of the day. I further destand that this eye exam may be performed by an Optometrist, an Opthalmologist, or another qualified specialist, and I consent to have my child receive the above exam and/or treatment. I conser all of the following services unless the boxes below are checked "no." urther 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) of uterials (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 of uterials. 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, it partments, employees, officers, contractors, volunteers, agents, and representatives, and the Board and its members, trustees, agents, officers, contractors, volunteers agents, or representatives, and employees from any liability which may accrue to me or my child, for any and all claims, losses, injuries, agents, or representative in which in part from the negligence of the City of Chicago is departments, employees, officers, contractors, volunteers, agents, or representatives. I further agree to release and hold harmless with a surface of the Board, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives. I further agree to release and hold harmless the form of liability that will arise out of roly re								
eye exam to allow the Provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops may include blurred vision an stairivity 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. I furthe deestand that this eye exam may be performed by an Optomerist; an Ophthalmologist, qualified specialist, or an intern, a resident, or a student clinician or technicia der the supervision of an Optometrist, Ophthalmologist, or another qualified specialist, and I consent to have my child receive the above exam and/or treatment. I consert all of the following services unless the boxes below are checked "no." urther 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) city of 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 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 considerations, and employees from any liability which may accrue to me or my child, for any and all claims, losses, indices, agents, officers, contractors, volunteers resentatives, and employees from any liability which may accrue to me or my child, for any and all claims, losses, injuries, damages or liabilitie util in whole or in part from the negligence of the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives or representatives in private, damages, or liabilitie util in whole or in part from the negligence of the City of Chicago, its departments, employees, officers, or representatives or representatives in the provider of the provider of the providers of the quality of the eyeglasses or an error materials. Furnished by them under the						as recommended for a comprehensive		
aterials (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 of a terials. 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, is partments, employees, officers, contractors, volunteers, agents, contractors, volunteers, agents, employees, officers, contractors, volunteers, agents, employees, officers, contractors, volunteers, agents, or 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 an known, forescen and unforescen, arising in connection with my child's receipt of services and materials, whether or not said claims, losses, injuries, damages, or liabilitie ult in whole or in part from the negligence of the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives, agents, or representatives, or from the agent and the Board, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives, agents, or representatives, agents, or representatives, and the provise of the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives, agents, or agents, and agents,	an eye exam to allow the Provider to co sensitivity to light, both of which could understand that this eye exam may be under the supervision of an Optometrist	nduct a thorough eye h restrict my child's mo performed by an Opton , Ophthalmologist, or a	nealth exam. I further und bility making it unsafe for metrist; an Ophthalmolog unother qualified specialis	derstand that the temporary effer r him/her to travel unassisted or gist; qualified specialist; or an i	cts of these eye r to operate a ve ntern, a resider	drops may include blurred vision and chicle for the rest of the day. I further at, or a student clinician or technician		
partments, employees, officers, contractors, volunteers, agents, and representatives, and the Board and its members, trustees, agents, officers, contractors, volunteers resentatives, 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 an known, foreseen and unforeseen, arising in connection with my child's receipt of services and materials, whether or not said claims, losses, injuries, damages, or liabilitie ult 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 gligence of the Board, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives, or representatives, or from the broiders and Co-Sponsors, their employees, officers, volunteers, agents and representatives from and against any and all claims, demands, actions, complaints, suits of the contractives of the provider of the part of the provider of the quality of the eyeglasses or an err 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 hel enforceable, that provision shall be severed and the remainder of the form shall remain in effect. Inderstand that the Provider will bill the Illinois Department of Healthcare and Family Services (HFS) or any other currently applicable insurance for any reimbursable vices and/or materials. Inderstand that my child may be selected to be photographed, video taped, audio taped or interviewed as part of promotional documentation for the Vision Program. Insent 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 mensation, monies, or reimbursement for my child's eyes to be dilated At this time I DO NOT consent for my child's eyes to be dilated At this time I DO NOT consent								
inderstand that my child may be selected to be photographed, video taped, audio taped or interviewed as part of promotional documentation for the Vision Program. Insent 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 not mpensation, monies, or reimbursement for my child's participation. 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. At this time I DO NOT consent for my child's eyes to be dilated. At this time I DO NOT consent for my child to be photographed or interviewed. At this time I DO NOT consent for my child to be surveyed to determine if glasses, if prescribed, are helping. You 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 citicago (Board) to release and furnish information regarding past vision screening data in my child's education record to Providers to ensure that the Providers of exam, for inclusion in my child's education record. I also authorize to my child's school, including written and verbal reports concerning the results of an 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 provide eather 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 object to the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinoi epartment of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for nefits on this authorization is valid for one year. I may revoke this aut	departments, employees, officers, contrepresentatives, and employees from an unknown, foreseen and unforeseen, arist result in whole or in part from the negligence of the Board, its members, Providers and Co-Sponsors, their emplother forms of liability that will arise out other materials furnished by them unother	ractors, volunteers, age y liability which may a ing in connection with ligence of the City of of trustees, employees, of oyees, officers, volunt- at of or by reason of, or there the Program, unle-	ents, and representatives, accrue to me or my child, my child's receipt of serv Chicago, its departments, officers, contractors, volu- eers, agents and represent r be caused by any perfors ss attributed to their wi	and the Board and its membe for any and all claims, losses, rices and materials, whether or r employees, officers, contractor inteers, agents, or representative tatives from and against any a mance of services provided by llful or wanton misconduct. In	rs, trustees, ag injuries, damag not said claims, rs, volunteers, res. I further ag nd all claims, o such Providers	ents, officers, contractors, volunteers, es to me or my child, both known and losses, injuries, damages, or liabilities agents, or representatives, or from the gree to release and hold harmless the demands, actions, complaints, suits or or the quality of the eyeglasses or any		
nsent 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 n mpensation, monies, or reimbursement for my child's participation. 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. At this time I DO NOT consent for my child's eyes to be dilated At this time I DO NOT consent for my child to be photographed or interviewed At this time I DO NOT consent for my child to be surveyed to determine if glasses, if prescribed, are helping I 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 ca extively 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 an 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 provider 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 partment of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for nefits on this authorization or my refusal to sign such authorization at any time by sending written notification to CDPH, my child's school, or the Board Office of udent Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclose	understand that the Provider will bill services and/or materials.	the Illinois Departmen	at of Healthcare and Fam	ily Services (HFS) or any other	currently appl	icable insurance for any reimbursable		
At this time I DO NOT consent for my child's eyes to be dilated At this time I DO NOT consent for my child to be photographed or interviewed At this time I DO NOT consent for my child to be surveyed to determine if glasses, if prescribed, are helping resigning 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 concerning the results of an 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 the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinoi expartment of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for nefits on this authorization or my refusal to sign such authorization at any time by sending written notification to CDPH, my child's school, or the Board Office of adent Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclose	consent to the use of my child's photo	graph, voice or likenes	s by the Board or the Pr	ped or interviewed as part of provider or CDPH, but not the us	romotional doct se of my child	mentation for the Vision Program. Is last name. I understand there is no		
At this time I DO NOT consent for my child to be photographed or interviewed At this time I DO NOT consent for my child to be surveyed to determine if glasses, if prescribed, are helping r 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 Licago (Board) to release and furnish information regarding past vision screening data in my child's education record to Providers to ensure that the Providers call certively 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 an 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 the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinois partment of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for the defent has authorization or my refusal to sign such authorization at any time by sending written notification to CDPH, my child's school, or the Board Office of the defent has a construction. Inform	If you do NOT want your child to receive	ve the following service	es, please check the appro	priate box. Please note services	will be perform	ned unless indicated otherwise.		
licago (Board) to release and furnish information regarding past vision screening data in my child's education record to Providers to ensure that the Providers calectively 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 an 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 the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinois partment of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for the privacy rights afforded by state and the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for the purpose of this authorization or my refusal to sign such authorization. It is 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 the deleth and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclose	☐ At this time I DO NOT consent	for my child to be pl	hotographed or interview		elping			
udent Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclose	Chicago (Board) to release and furnise effectively provide services. I authorize eye exam, for inclusion in my child's exwhether my child was recommend for subject to the privacy rights afforded Department of Healthcare and Family States.	n information regardine the Providers to relea lucation record. I also follow-up services, and by state and federal la Services (HFS), for the	g past vision screening use and furnish reports to authorize CDPH to releas d other information the S w. I further authorize Pr e purpose of insurance bi	data in my child's education r my child's school, including we te to the Board, my child's infor- tate of Illinois requests the Bo oviders to disclose vision exam-	record to Provi- ritten and verbates mation, the data ard to report. In information a	ders to ensure that the Providers can I reports concerning the results of any e and type of vision services provided. I understand that such records will be and billing information to the Illinois		
	Student Health and Wellness. Revoki	ng this authorization w	vill not have any effect of					

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.

Date:

Parent/Guardian Signature:	Date:
----------------------------	-------



Student Medical History Form

Please Print: Student's Name:			Schoo	l Name: _				
Student's Date of last Eye I	Exam:	Doe	es your ch	ild curre	ntly wear glasses	or contacts?	□ Yes □ No	
How did you find out about School staff Failed Vi	t the Vision Pro		hat apply	Other_				
Does your child have any o	of the following	conditions: (Check	k all that	apply)				
□ Asthma □ Behavioral problem □ Neurological problems □ Endocrine problems □ Heart Disease □ Mental Health illnes □ Hearing/Ear problems □ Diabetes		ocrine problems tal Health illness	 □ Attention Deficit Disorder □ High Blood Pressure □ Gastrointestinal problems □ Other Condition 			☐ Glaucoma☐ Musculoskeletal problems☐ Genitourinary problems		
Is your child taking any medications? □No □Yes List medications:				Does your child have allergies? □No □Yes List allergies:				
Does your child use eye dro List eye drops:	ops?	□No □Yes		ur child e	ever had eye surg plain:	gery? □No [∃Yes	
Has s/he had any of the foll	lowing?							
Vision Therapy Eye patch Eye Surgery Pain in eyes Difficulty Tracking Lazy/Wandering Eye Blurred/Double Vision Loses place while reading Other		Eye Injury Eye Infection Itching/Burning Eye Discharge Tearing/Waterin Light sensitivity Redness Drooping Lid	□ No ng □ No	☐ Yes	Trouble finishing Lack of confide Difficulty sitting Avoids reading Difficulty paying Reads below go Poor handwrite Frustrates easily	ence ng still g/writing ng attention rade level ing	 □ No □ Yes 	
Does your child have an IE	P (Individualize	ed Education Plan	?	□No	□Yes			
Is the child performing at: ☐ above grade level				\square grade level \square below grade level			grade level	
If below grade level, please ☐ Reading	e select the class	s (Check all that ap ☐ Math			ocial Studies	□ Other		
Is the child currently receiv ☐ Special Education		services below? (C ☐ Speech Therapy				□ Physica	al Therapy (PT)	
List any of your child's Ho	bbies or Specia	l Interests:						
Is there anything else you following? (Check all that a				ld?Does	your child's im	mediate fam	ily member have any of	
☐ Wears glasses ☐ Wandering Eye ☐ Glaucoma ☐ Blindness ☐			□ Diabetes□ Musculoskeletal problems□ Heart Disease			☐ Cardiovascular problems ☐ Neurological problems ☐ Mental Health illness		