Office of Student Health and Wellness
125 South Clark Street, Suite 900 • Chicago, Illinois 60603
Telephone: 773-553-1800 • Fax: 773-553-1883

March 21, 2013

Dear Parent/Guardian:

Good vision is vital to student learning and CPS provides students with access to vision exams so they may succeed in school. Your child has the opportunity to participate in the CPS Vision Program that provides students with eye exams and glasses at no cost to the student. Please read the review the following information to see if vision services would benefit your child:

- Vision exams are required for students:
  - Entering kindergarten
  - Entering Illinois schools for the first time at any grade level
- Vision exams are recommended for students:
  - Who failed the vision screening
  - With an IEP
  - Recommended by their teacher to receive an eye exam
  - Who experience squinting, tilting the head, sitting too close to the television, losing place while reading, rubbing eyes, excessive tearing or headaches

Your child will receive services in the following way:

☐ Princeton Vision Clinic - Students will travel by bus with school assigned adult supervision to the clinic located at Princeton Elementary School (5125 S. Princeton)

OR

☐ School Based Vision Services – Doctor will come to your school to provide a comprehensive vision exam

Following the eye exam, if your child requires glasses, a vision technician will assist your child with picking out a frame and the glasses will be delivered to the school within 6-10 weeks. Health insurance will be billed if available. If the student has no insurance, vision exams are provided at no cost to the family.

To allow your child to participate, please read and complete both sides of the enclosed consent form and return it to your child's school immediately. Your child will not be able to participate if his/her enclosed consent form is not signed and returned to school. If your child received an eye exam within the past year, these services are not necessary.

If you have any questions or concerns, please contact your child's school or Katheryn Stafford-Hudson at 773-535-8675 or kgstafford-h@cps.edu.

Sincerely,

Stephanie A. Whyte MD, MBA

Chief Health Officer
3/8/2013

Vision Services
Consent and Authorization Form

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

School Name: _____Student ID# _____Grade: _____Room# _____

Parent/Guardian Name: _____Home Address: _____Phone: _____

Race/Ethnicity_____ _____Medicaid/ALLKids 9 digit recipient #_____

Other Insurance: _____Group ID_____ ID#_____ Cardholder Name: _____

As the parent/guardian of the above name student, I understand that my child failed a vision screening test performed at school, or was recommend for a comprehensive eye exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional (Provider).

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 may 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. 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 the above exam and/or treatment. I consent to all of the following services unless the boxes below are checked "no."

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.

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

I understand that my child may be selected to be photographed 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.

I hereby give my consent for this child to be examined by a Provider for an eye exam and prescription eyeglasses, if prescribe**d** 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.

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.

☐ 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

Please sign and date to consent for services and complete the medical history on reverse side of this form.

Parent/Guardian Signature: _____Date:_____

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.

Parent/Guardian Signature:_____Date:_____

CHICAGO PUBLIC SCHOOLS | CPS

Student Medical History Form

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 or an immediate family member have any of the following (check all that apply)

Diabetes	☐Yes	☐No	Who? _____
Glaucoma	☐Yes	☐No	Who? _____
High Blood Pressure	☐Yes	☐No	Who? _____
Allergies (list)	☐Yes	☐No	Who? _____

Is your child taking any medications? ☐Yes ☐No list medications _____

Has s/he had any of the following?

Vision Therapy	☐Yes	☐No	Eye Injury	☐Yes	☐No	Tearing/Watering	☐Yes	☐No
An eye patched	☐Yes	☐No	Eye Infection	☐Yes	☐No	Drooping Lid	☐Yes	☐No
Eye Surgery	☐Yes	☐No	Itching/Burning	☐Yes	☐No	Redness	☐Yes	☐No
Pain in eyes	☐Yes	☐No	Eye Discharge	☐Yes	☐No			
Difficulty Tracking	☐Yes	☐No	Blurred/Double Vision	☐Yes	☐No			
Lazy/Wandering Eye	☐Yes	☐No	Light sensitivity	☐Yes	☐No			
Poor handwriting	☐Yes	☐No						

Other_____

Does your child have an IEP? ☐Yes ☐No

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

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)

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

☐Asthma	☐Cardiac problems	☐Endocrine problems	☐Trouble finishing work
☐Difficulty paying attention	☐Behavioral problems	☐Neurological problems	☐Heart Disease
☐Musculoskeletal problems	☐Frustrates easily	☐Avoids reading/writing	
☐Attention Deficit Disorder	☐Mental Health illness	☐Gastrointestinal problems	
☐Difficulty sitting still	☐Loses place while reading	☐Hearing/Ear problems	☐Lack of confidence
☐Reads below grade level	☐Genitourinary problems		

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)

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