

Kids Vision for Life

PARENT FACT SHEET

Things every parent should know about vision:



- 1) Vision problems that are not corrected can reduce a student's ability to read, concentrate and process information
 - 2) Healthy vision is a critical part of learning well in school
 - 3) 80% of all learning during a child's first 12 years is obtained through vision
(Source: Journal of Behavior Optometry)
 - 4) It is estimated that 25% of school-aged children have vision problems
(Source: American Optometric Association)
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We can help:

- Your child can get **FREE** eye glasses through vision clinics sponsored by the City of Houston Department of Health and Human Services and other agencies who participate in a collaboration called Kids Vision for Life.
 - At a vision clinic, a licensed provider will check your child's vision and prescribe glasses if needed.
 - Your child will choose his/her own frame after the exam if glasses are needed
 - Glasses will be delivered to the school within 6 weeks of the vision clinic
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Act now to get your child's vision problem corrected:

- Fill out the 3 page consent form below and sign the form
 - Return the completed form to your child's school by
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Student information Form

Student Name: _____ School Name: _____

Student Address/Zip: _____

Parent/Guardian Name: _____

Parent/Guardian Contact Number: _____

Student DOB: _____ Age: _____ Male Female

Health History

In order to help facilitate the eye exam please complete this brief health history for the child named above.

My child is taking (list medications): _____

My child is allergic to: _____

My child has (check all that apply): _____ Heart surgery or murmur _____ Asthma

_____ High blood pressure _____ Epilepsy _____ Diabetes _____ Other (please describe)

Please check off any of the following conditions your child currently has or had in the past:

_____ Eye disease _____ Turned eye _____ Eye surgery _____ Double vision

_____ Color vision defects _____ Lazy eye _____ Glaucoma _____ Vision therapy

_____ Flashes of light _____ Cataracts _____ Uses glasses _____ Laser treatments

_____ Contact lenses _____ Using any eye medications

List any known problems your child has had in regards to his/her vision and/or eye health:

Billing Information:

Does your child have Medicaid or CHIP (please circle the correct answer): Yes No

If yes, please write the Medicaid or CHIP number below so that we may bill for eligible services provided.

Medicaid ID Number: _____

CHIP ID Number: _____

Parental Consent Form for Vision Services

Clinic Date: _____

Clinic Location: _____

I, _____ parent/guardian of, _____
(Print child's name) give my permission for my son/daughter to receive an eye exam and eyewear, if needed, on the above date and time at the above location.

I also grant permission for the Houston Department of Health & Human Services to access and receive school performance records from my child's school or district regarding attendance, behavior and academic performance for the purpose of researching and evaluating this program's effectiveness. I understand that these records will be kept confidential.

Release of Liability:

I release from any liability associated with this event the officers, directors, employees, agents, affiliates, and/or assigns of the following groups: optometrist(s) who perform the eye exam; the cosponsoring agency, Houston Department of Health and Human Services' Vision Partnership.

Waiver of Dilated Fundus Exam:

The state board of optometry may require a dilated fundus exam as part of an eye examination performed by a licensed optometrist. A dilated fundus exam is a thorough exam of the peripheral retina aided by the use of topical dilating eye drops. This procedure is used to diagnose abnormalities of the retina such as detachments, tears, tumors, infections, hemorrhages and genetic abnormalities. The dilating drops will leave the pupils dilated for approximately four hours. During this period the patient may experience blurry vision and light sensitivity. Reading may be difficult during this time period.

I do _____ do not _____ give my permission for the optometrist to perform a dilated fundus exam during the examination process on the Vision Partnership Clinic.

Permission to Photograph Child:

This event may be photographed or filmed by the Vision Partnership for internal communications for future use in publications, video tapes or other educational presentations. When these photographs/images are used in this way, your child's case history and other test results may also be used to describe the health and the condition of your child's eyes. At no time, however, will your child's name be made public. Photographs/footage will not be used for advertising, eyewear product endorsement, and/or commercial use.

I do _____ do not _____ give my permission for my child to be filmed or photographed and understand that my decision will not affect whether my child receives an eye exam or glasses at this Clinic.

SIGN HERE: _____ **DATE:** _____