Vision Services Consent, Release of Liability, and Authorization Form

Chicago Public Schools

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.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME
GENDER	STUDENT DATE OF BIRTH	SCHOOL NAME
STUDENT ID #	GRADE	ROOM #
PARENT/GUARDIAN NAME	PARENT EMAIL ADDRESS	
PHONE	HOME ADDRESS (include unit number if applicable)	CITY / STATE / ZIP
MEDICAID/MEDICAL CARD/ALLKIDS RECIPIENT #	RACE/ETHNICITY	DATE OF BIRTH
PRIVATE VISION INSURANCE	CARDHOLDER NAME	GROUP ID# / ID#
PRIVATE MEDICAL INSURANCE	CARDHOLDER NAME	GROUP ID# / ID#

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.

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.

Please note services will be performed unless indicated otherwise.

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.

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

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 re-disclosure by the recipient.

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 an original signature; an electronic signature is not acceptable.

Student Medical History Form

Chicago Public Schools

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please print or type:

STUDENT NAME	STUDENT'S DATE OF LAST EYE EXAM
SCHOOL NAME	DOES YOUR CHILD CURRENTLY WEAR GLASSES/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? ☐ YES ☐ NO

List Medications

DOES YOUR CHILD HAVE ANY ALLERGIES? ☐ YES ☐ NO

List Allergies

DOES YOUR CHILD USE EYE DROPS? ☐ YES ☐ NO

List Eye Drops

HAS YOUR CHILD EVER HAD EYE SURGERY? ☐ YES ☐ NO

If yes, please explain

HAVE THEY HAD ANY OF THE FOLLOWING?

☐ Vision Therapy ☐ Blurred/Double Vision ☐ Tearing/Watering ☐ Difficulty sitting still ☐ Frustrates easily

☐ Eye patch ☐ Loses place while reading ☐ Light sensitivity ☐ Avoids reading/writing ☐ Lack of confidence

☐ Eye Surgery ☐ Eye Injury ☐ Redness ☐ Difficulty paying attention ☐ Eye Discharge

☐ Pain in eyes ☐ Eye Infection ☐ Drooping Lid ☐ Reads below grade level ☐ Lazy/Wandering Eye

☐ Difficulty Tracking ☐ Itching/Burning ☐ Trouble finishing work ☐ Poor handwriting

☐ Other _____

DOES YOUR CHILD'S IMMEDIATE FAMILY MEMBER HAVE ANY OF THE FOLLOWING? (Check all that apply and the relationship to child)

YES ☐ NO ☐ Wears glasses YES ☐ NO ☐ Glaucoma YES ☐ NO ☐ Lazy eye YES ☐ NO ☐ High Blood Pressure

YES ☐ NO ☐ Blindness YES ☐ NO ☐ Macular Degeneration YES ☐ NO ☐ Diabetes YES ☐ NO ☐ Wandering Eye

YES ☐ NO ☐ Heart Disease YES ☐ NO ☐ Cardiovascular problems YES ☐ NO ☐ Neurological problems YES ☐ NO ☐ Mental Health illness

YES ☐ NO ☐ Musculoskeletal problems

DOES YOUR CHILD HAVE AN IEP (Individualized Education Plan)? ☐ YES ☐ NO

IS YOUR CHILD PERFORMING AT: ☐ Above grade level ☐ Grade level ☐ Below grade level

IF BELOW GRADE LEVEL, PLEASE SELECT THE CLASS (Check all that apply) ☐ Reading ☐ Math ☐ Social Studies ☐ Writing ☐ Other _____

IS THE CHILD CURRENTLY RECEIVING ANY OF THE SERVICES BELOW?

☐ 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?