Association for the Blind & Visually Impaired Charleston

Permission Slip for FREE In-School Eye Exam

Dear Parents and Guardians,

The Association for the Blind and Visually Impaired - Charleston is promoting eye health and proper eye care in local Charleston County schools. We will be preforming vision screening for your child with our PlusOptix machine. If you have signed something disallowing screening for your child they will not be eligible for any part of this program. If your child is referred by the screener, or if the test is inconclusive, we will return to the school to do a **free** eye exam (ONLY IF YOU HAVE SIGNED THIS FORM). Following the exam, if needed, your child is eligible to receive **free** prescription eye glasses at no charge to you. The funds for this program come from grants and private donations. Your child's Medicaid will **not** be billed. The exam will be held during school hours. He/she will receive the glasses within three weeks of the exam.

ALL YOU NEED TO DO IS SIGN & RETURN THE ATTACHED CONSENT FORM.

This is a fantastic opportunity to provide your child with free eye exams and eyeglasses!!

Please fill out the attached medical form and permission slip. Without the form, we cannot provide this service!!!

Thank You,

The Association for the Blind and Visually Impaired – Charleston
ReFocus on Children Program Team
843.723.6915

ReFocus on Children – Medical History Form

(Please Print Clearly)

Student Information

Name	
Male or Female	
Student's Birth Date	
Race	
Phone	
Parent / Guardian Name	
Parent/Guardian's Work Phone	
Complete Home Address	

Medical Information

Student's Eye Doctor (if any):		**Date of Last Visit:**	
Student's Medical Doctor:		**Doctor's Phone #**	
Is your child allergic to (please circle): Latex Other:			
Please list any medications your child is taking and why:			

Does your child have any of the following?

	Yes	**No**		**Yes**	**No**
Abnormal Blood Pressure			Family history of retina problems		
Allergies			Family history of glaucoma		
Asthma			Family history of cataract		
Diabetes			Family history of crossed eyes		
Eye Disease			Family history of strong eyeglasses prescription		
Heart Condition					

Does your child have any disease, condition, or problem not listed above? If yes, please list:

Child's Medicaid number: *Be sure to fill out all 10 numbers*										
Child's Full Name on Card:										

*** Medicaid information is taken for grant purposes, and to let us know which doctor to recommend if we need to refer your child for a more serious eye condition. We will not use the children's names in our grants.

Permission Slip for Vision Exam at School

Child: _____
(***Print name***)

Parent/legal guardian: _____
(***Print name***)

I, the parent/legal guardian of the above named child, understand that the Association for the Blind and Visually Impaired - Charleston, in conjunction with the Medical University of South Carolina, Storm Eye Institute and others have developed a program with the goal of locating children who may need corrective lenses for vision and supplying their families in obtaining such corrective lenses.

If my child does not pass the ABVI vision screening administered at his or her school, I authorize the licensed optometrist or ophthalmologist who will return to the school to perform an eye exam using standard ophthalmic procedures, which will include the use of dilation drops. I understand there will be no charge for vision screenings or eye exams and glasses if necessary performed at my child's school. If the optometrist or ophthalmologist examines my child and determines it appropriate, information shall be sent home recommending a referral for further pediatric ophthalmological care. I understand eye exams should be conducted regularly, as eyes may change over time. Children who pass the vision screening will not receive an eye exam. However, I understand a vision screening does not replace a complete eye exam performed by a licensed optometrist or ophthalmologist.

_____

Signature of parent/guardian

Date: _____