Mobile Vision Consent Form | Toledo-Lucas County Health Center

PLEASE COMPLETE (YES OR NO), SIGN, AND RETURN TO SCHOOL IMMEDIATELY.

CHILD'S LAST NAME _____ **FIRST NAME**_____ ☐**FEMALE** ☐**MALE**

SCHOOL _____ **GRADE** _____ **TEACHER** _____ **RM #** _____

PLEASE CHECK YES OR NO AND COMPLETE THE FORM AS INDICATED:

☐ **YES**, I have read the information about the vision care program and I give my informed consent for my child to participate in the Mobile Vision Program and receive an eye exam (not screening). Please complete the rest of this form, both PRINT & SIGN at the bottom and return it to school.

☐ **NO**, I do not want my child to receive an eye exam. Stop here and sign _____

CHILD'S DATE OF BIRTH _____/_____/_____

ADDRESS _____ **CITY** _____ **ZIP**_____

PHONE _____ **EMAIL** _____

Race *(Mark all that apply)*	White	Black/African American	Asian	Pacific Islander/ Native Hawaiian	Native American/ Alaskan Native	Unknown	Other

Is your child Hispanic? ☐ Yes ☐ No

Date of last eye exam _____/_____/_____ **Where?** _____

Does your child wear glasses? ☐ **Yes** ☐ **No** **Child's doctor** _____

Does the child have any health problems? ☐ **Yes** ☐ **No**

If yes, please list _____

Please list your child's allergies _____

What (if any) medications does your child take? _____

Has the child been exposed to lead? ☐ **Yes** ☐ **No**

Do you (the parents) have any health problems? ☐ **Yes** ☐ **No**

If yes, please list _____

Our program is partly funded by government agencies. If you have one of the insurances listed below, your child's information is required. Their insurance WILL BE BILLED, but there will be NO OUT-OF-POCKET expense to you.

☐ PARAMOUNT ADVANTAGE ☐ buckeye health plan ☐ CareSource ☐ UnitedHealthcare Community Plan ☐ MOLINA HEALTHCARE ☐ Other Medicaid

Billing or ID# _____ **MMIS#** _____

Effective Date _____ **Child's SSN** _____-_____-_____

Insured's Name _____ **Insured's Date of Birth** _____/_____/_____

Income: Which of these best represents your annual household income? (Circle one)

Less than $10,000 *$10,000 - $20,000* *$20,000 - $30,000* *$30,000 - $40,000* *More than $40,000*

Total Household Size _____ (include yourself, significant other, and children)

I have read and completed the information on this form and my signature below gives consent for the exam and is valid for this school year. I have read and understand the Notice of Privacy Practices. This form, when signed and filled in, contains Protected Health Information and the information is to be protected according to the Health Insurance Portability and Accountability Act (HIPAA).

SIGN HERE _____ _____

Parent/Guardian Signature **Date**

PRINT HERE _____

Print Parent/Guardian Name