Mobile Vision Consent Form | Toledo-Lucas County Health Center

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

- Your student can receive a **COMPREHENSIVE EYE EXAM** by our eye doctor at school during the 2017-18 school year. (Not a vision screening).
- If prescribed, your child will be fitted with glasses which will be dispensed at school.
- Services are provided by The Toledo-Lucas County Health Center, 635 N. Erie St. Toledo, Ohio 43604

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. I understand my child will receive an eye exam and glasses, if needed, which may require the use of dilation drops. 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 *(Circle 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 have a wandering, crossed, or lazy eye? ☐ **Yes** ☐ **No** **Ever told to patch good eye?** ☐ **Yes** ☐ **No**

Does your child wear or ever had glasses? ☐ **Yes** ☐ **No** **Has the child been exposed to lead?** ☐ **Yes** ☐ **No**

Had head trauma? ☐ **Yes** ☐ **No Is this child being evaluated for 504, IEP, or other learning disabilities?** ☐ **Yes** ☐**No**

Name of child's doctor/pediatrician_____

Please list any serious health problems your child has _____

Please list your child's allergies _____

List any medications your child takes? _____

Please list any health problems their parents have _____

Our program is partly funded by government agencies. If you have insurance, please list it below. Their insurance WILL BE BILLED, but there will be NO OUT-OF-POCKET expense to you.

☐ PARAMOUNT ADVANTAGE ☐ buckeye health plan ☐ CareSource ☐ UnitedHealthcare ☐ MOLINA HEALTHCARE ☐ Other ins.

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, where a copy can be found at lucascountyhealth.com. This form, when signed and filled in, contains Protected Health Information and the information is to be protected according to HIPAA.

SIGN HERE _____ _____

Parent/Guardian Signature **Date**

PRINT HERE _____

Print Parent/Guardian Name