

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)



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



Act now to get your child's vision problem corrected:

- Fill out the attached parental consent form below and sign the form
- Return the completed form to your child's school by _____



PARENTAL CONSENT FORM AND HEALTH HISTORY FOR VISION PARTNERSHIP

Student ID (filled out by school officials): _____

Student Information

Student Name: _____ School Name: _____

Student Address/Zip: _____

Parent/Guardian Name: _____

Parent/Guardian Contact Number: _____

DOB: _____ Grade: _____ Male ☐ Female ☐

Race (Check All That Apply)

- | | | |
|-----------------------------------------------------------|--------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> White | <input type="checkbox"/> Other <input type="checkbox"/> Don't Know |

Ethnicity (Check Only One)

- | |
|---------------------------------------|
| <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Non-Hispanic |

Health History: Please complete the following health history for your child.

Please check off any of the following eye conditions your child currently has or has had in the past
Check for "YES"

None/No Known Eye Conditions	
Uses Glasses	
Contact Lenses	
Eye Disease	
Lazy Eye	
Cataracts	
Turned Eye	
Glaucoma	
Eye Surgery	
Eye Injuries	
Laser Treatments	
Double Vision	
Vision Therapy	
Color Vision Defects	
Flashes of Light	
Using ANY Eye Medications	

	Check for "YES"	List
Does your child have allergies?		
Is your child taking any Medications?		

Does your child or any immediate family member (parent, grandparent, or sibling) have any of the following health conditions
Check for "YES"

If YES, whom?
(parent, grandparent, sibling)

Diabetes		
Glaucoma		
High Blood Pressure		

	List problems /symptoms
Any additional vision or eye health problems or symptoms your child is having?	

Kids Vision See to Succeed Information

The ultimate goal of "Vision Partnership" is to provide eyewear for school age children that are identified by school nurses every year as needing glasses.

If your child needs eyewear based on the results of the eye examination provided by a licensed optometrist, a trained optician will assist your child in selecting a pair of glasses that are suitable for his/her prescription, face shape, and features.*

The entire process, from registration at the stated appointment time to the completion of the eye exam and eyewear, will take 2-4 hours. Please make arrangements to ensure that your child will have available any necessary medications and/or food that will be needed during this time period. Due to space limitations, parents cannot accompany the child during a Clinic.

If you want your child to participate in this program please complete the attached parental consent form with the requested information and sign the form. **Failure to return this form with the appropriate signatures will result in forfeiture of your child's appointment.**

**** Vision Partnership does not provide any breakage protection warranty on the glasses. Vision Partnership will not replace glasses that are lost, stolen or broken.***

Consent for Vision Services:

I give my permission for my son/daughter to participate in a Vision Partnership during the 2014-2015 school year and to receive a free eye exam and eyewear, if needed and necessary referral and follow up.

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, Vision Partnership.

Privacy Notification:

With few exceptions, you have the right to request and be informed about information that the City of Houston collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the city agency to correct any information that is determined to be incorrect. For further information, contact Carolyn Sebile, Privacy Officer, Houston Department of Health and Human Services at Carolyn.Sebile@houston.tx.gov.

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.

Permission to Photograph Child:

This event may be photographed or filmed by 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.

General Consent Statement

I understand my child must return a signed consent form before services can be provided.

I give consent for my child to receive a free eye exam. I understand that a licensed eye doctor will perform the exam. I understand that my child may receive free glasses only if needed.

I give consent for HDHHS to access school performance data.

I release from any legal responsibility any staff at this event.

I have been given a copy of HDHHS' Privacy Notice.

√ _____
Signature of Parent

√ _____
Date

Consent to Dilate Eyes

I give consent for my child's eyes to be dilated. I understand this is to check for possible vision defects or disease.

√ _____
Signature of Parent

√ _____
Date

Consent to Photo or Videotape

I give consent for staff to take pictures or video of my child. I understand these may be used for future educational materials.

√ _____
Signature of Parent

√ _____
Date