Office of Student Health and Wellness
42 W. Madison St., Chicago, IL 60602

Dear Parent/Guardian,

Good vision is essential for success in school. We are pleased to announce that the Chicago Public Schools (CPS) Vision Program will be serving your school this year! CPS provides access to vision exams for students so that they may succeed in school.

The CPS Vision Program provides eye exams and glasses (if needed) at **NO COST** to the student. If the student does not have insurance, the vision exam and eyeglasses are provided at no cost to the family. If available, health insurance will be billed.

Below are signs that indicate your child may benefit from an eye exam:

- ☐ My child is entering kindergarten
- ☐ My child is entering Illinois schools for the first time at any grade level
- ☐ My child failed the vision screening
- ☐ My child has an IEP
- ☐ My child's teacher recommended they receive an eye exam
- ☐ My child experiences any of the following:
  - Squinting
  - Tilting the head
  - Sitting too close to the television
  - Losing place while reading
  - Rubbing eyes
  - Excessive tearing or headaches

Complete the consent form by:

1. **Signing the two signature lines.**
2. Completing the last page with your child's medical history.
3. Returning the form to your child's school **as soon as possible** – Your child will not be able to participate without a signed consent form.

Following the eye exam, if your child requires glasses, an optician will assist your child with selecting the frame. Glasses will be delivered within 4-5 weeks to the school.

If you do not want your child to participate in the program, you do not need to complete or return the form to the school. However, if your child received an eye exam from an eye doctor outside of the CPS Vision Program please ensure your child's health records are up to date by having the doctor complete the State of Illinois Eye Examination Report found here: http://cps.edu/OSHW/Documents/VisionExaminationForm.pdf

If you have questions, please contact Katheryn Stafford-Hudson at 773-535-8675, or via email at kgstaffordh@cps.edu

Sincerely,

Kenneth G. Papineau
Manager

Vision Services
Consent, Release of Liability, and Authorization Form

Please Print: Parent Email Address _____

Student Name: _____ Student's Date of Birth _____ ☐ Male ☐ Female

School Name: _____ Student ID# _____ Grade: _____ Room# _____

Parent/GuardianName: _____ Home Address: _____ Phone: _____

Medicaid/ALLKids recipient # _____ Race/Ethnicity _____

Other Insurance: _____ Group ID _____ ID# _____ Cardholder Name: _____ Birth Date _____

As the parent/guardian of the above name student, I understand that my child failed a vision screening test performed at school, or was recommended for a comprehensive eye exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional (Provider).

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 may 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. 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 the above exam and/or treatment. I consent to all of the following services unless the boxes below are checked "no."

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 the Illinois Department of Healthcare and Family Services (HFS) or any other currently applicable insurance for any reimbursable services and/or materials.

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.

If you do NOT want your child to receive the following services, please check the appropriate box. Please note services will be performed unless indicated otherwise.

☐ At this time **I DO NOT** consent for my child's eyes to be dilated
☐ At this time **I DO NOT** consent for my child to be photographed or interviewed
☐ At this time **I DO NOT** consent for my child to be surveyed to determine if glasses, if prescribed, are helping

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.

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 redisclosure 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:** _____

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