2/16/2010

Dear Parent/Guardian:

Congratulations! Your child’s school has been selected to participate in the OneSight Vision Clinic. This clinic provides students with eye exams and eye glasses at no cost to the student. Students will travel by bus to the clinic, located at Jefferson School (1522 W. Fillmore). Following the eye exam if your child requires eye glasses they will pick out a pair and the glasses will be sent to the school within two-six weeks.

To allow your child to participate, please read and complete the enclosed consent form and return it to your child’s school immediately. Your child will not be able to participate if his/her consent form is not signed and returned to the school.

If you have any questions or concerns, please contact your child’s school or Virginia Montgomery, Coordinated School Health Specialist at 773-553-5662 or vamontgomery@cps.k12.il.us.

Sincerely,

Deborah E. Duskey
Chief Specialized Services Officer
OFFICE OF SPECIALIZED SERVICES VISION PROGRAM
CONSENT FOR FOLLOW-UP VISION SERVICES

Name of Child ___________________________  Child's Room Number ____________  Student ID# ____________

(Please Print Name)  (Please Print First & Last Name)

Child's Date of Birth ___/___/___  Age ___  School Name ___________________________

Under the Chicago Public Schools (CPS) Office of Specialized Services Vision Program (Program), CPS approves various vision care providers (Providers) to (i) provide follow-up comprehensive eye examinations to currently-enrolled CPS students who have failed their CPS vision screenings; and (ii) provide prescriptions eyeglasses when they are prescribed during these follow-up examinations. As part of these eye examinations it may be necessary to dilate students’ eyes to evaluate ocular health. The dilating drops will leave students’ pupils dilated for approximately four (4) hours; and during this 4-hour period students may experience blurry vision and light sensitivity, and may have difficulty reading. These problems will only be temporary. The eye examinations and insertion of dilating drops may be performed by any of the following: a licensed Optometrist, Ophthalmologist or some other qualified specialist, or by an intern or resident, or by a student clinician or technician under the supervision of a licensed Optometrist or Ophthalmologist, or some other qualified specialist.

Providers should release and furnish to schools, for inclusion in the students’ health records, written and verbal reports concerning the examinations and any services or eyeglasses provided. To let them give schools this information, please complete and sign the attached Authorization Form.

To document and publicize the Program, CPS and Providers may wish to interview, take photographs of, and videotape some students.

CPS will not oversee or supervise any of the Program services and is not liable for any services or any provided eyeglasses. By signing this Consent, you agree to release and hold harmless the Board of Education of the City of Chicago, its members, agents, officers, contractors (excluding the Providers), volunteers and employees 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 or non-performance of services provided by the Providers under the Program or the quality of any and all provided eyeglasses or other materials.

1. Do you give permission for dilating drops to be placed in your child’s eyes?  [Check one answer for each question.]
   - Yes
   - No

2. Do you give permission for your child to be interviewed, photographed or videotaped?  [Check one answer for each question.]
   - Yes
   - No

3. Does your child or does an immediate family member (parent, grandparent, or sibling) have any of the following?
   a) Diabetes
   b) Glaucoma
   c) High Blood Pressure

4. Does your child have any allergies?

5. Is your child currently taking any medications?

6. By signing this Consent, you agree to all of the following:
   a) I consent for my child to receive from an approved Provider a comprehensive eye examination and prescription eyeglasses if they are prescribed during the examination, and I consent for CPS to give this Provider a copy of this signed Consent Form.
   b) I agree to release and hold harmless the Providers, and 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 or non-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.
   c) With respect to the Program documentation and publicity materials, I consent to have my child be interviewed, photographed and videotaped. I consent to this use of my child's photographs, voice and likeness, but not the use of my child's name. I agree to release and hold harmless the Board of Education of the City of Chicago, its members, agents, officers, contractors, volunteers and employees 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 such use of my child or its/their voice or photograph in the Program documentation and advertising. I understand and agree that no inquires or other consideration in any form, including reimbursement for any expenses incurred by me or my child, will become due to me or my child or any of our heirs, agents, or assigns at any time because of my child’s participation in these documentation and publicity activities or the above-described use of my child or its/their photograph, likeness or voice.

I understand that this Consent will expire at the end of the current school year unless I revoke it sooner by sending written notice of my Withdrawal of Consent to my child’s school principal. I understand that any such Withdrawal of Consent will not take effect for ten (10) business days following its receipt by my child’s school principal.

PARENT/GUARDIAN SIGNATURE: _______________________________  Date: ___/___/___

PRINT PARENT/GUARDIAN NAME: _______________________________

OSS Vision Consent 2008-2013 (rev. 10/1/08)  Please See Back
OFFICE OF SPECIALIZED SERVICES VISION PROGRAM

AUTHORIZATION FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Child’s Name ________________________________ Date of Birth ___/___/____ School Name ________________________________

(Please Print Name) ________________________________ (Please Print First & Last Name)

Child’s Address __________________________________________

By signing this Authorization Form for the Use and Disclosure of Protected Health Information, I understand that I am giving my authorization to any approved vision services provider (Provider) under the Chicago Public Schools (CPS) Office of Specialized Services Vision Program (Program) to use and/or disclose to my child’s school and to the CPS Office of Specialized Services protected health information (PHI) relating to vision services (including the provisioning of prescription eyeglasses) provided to my child under the Program.

This authorization will expire at the end of the current school year unless I revoke this authorization sooner by sending written notification to my child’s school principal and to the CPS Office of Specialized Services as specified below. I understand that any such revocation will not have any effect on any information already used or disclosed by the Provider before my child’s school principal and the CPS Office of Specialized Services receives the written notice of revocation.

Notice to the School: Send notice to the school’s principal.

Notice to CPS Office of Specialized Services: Chicago Public Schools
Office of Specialized Services
125 South Clark Street - 8th Floor
Chicago, IL 60603

I understand that this Authorization is voluntary and I may refuse to sign this Authorization Form. I also understand that even if I refuse to sign this Authorization Form, Provider may still provide follow-up vision services to my child under the Program if I have signed the Office of Specialized Services Vision Program Consent for Follow-Up Vision Services.

I also understand that I have the right to be provided with a copy of this signed authorization form.

________________________________________________________
SIGNATURE OF PARENT OR GUARDIAN

Date

________________________________________________________
PRINT NAME OF PARENT OR GUARDIAN

Relationship to child

CPS Vision Consent 2008-2015 (rev. 6/1/08)

Please See Front