Free Vision Exam Permission Slip

ALCON CHILDREN'S VISION CENTER

Your child has been identified as having a POTENTIAL VISION PROBLEM. VISION EXAMS and GLASSES are available for your child at **NO COST TO YOU!** A scheduled clinic will be happening soon, but you must complete this permission form **for your child to receive this free benefit.**

Student Name: _____

Date of Birth: _____ **Gender:** _____ **Student ID:** _____

Mailing Address: _____

Phone Number: _____

Return Signed Form by_____

Parent/Guardian Signature: _____ **Date:** _____
By signing, I give permission for my child to get a vision exam and glasses (if prescribed). *

I give permission for my child's eyes to be dilated as part of their vision exam, if the doctor recommends it as medically necessary.** ☐ **Yes** ☐ **No**

I give permission for my child to be photographed*** ☐ **Yes** ☐ **No**

Has your child ever had an eye exam? ☐ **No** ☐ **Yes** Does your child currently wear glasses? ☐ **No** ☐ **Yes**

Has your child had a serious eye injury or surgery? ☐ **No** ☐ **Yes (please describe)** _____

Does your child have any chronic health problems? _____
(ex. diabetes, asthma, heart disease, etc.)

Does your child have any of the following symptoms?
(Check all that apply)

☐ **Squinting**	☐ **Gets close to the page to read/write**	☐ **Avoids close work**
☐ **Headaches**	☐ **Difficulty seeing far away**	☐ **Rubs eyes frequently**
☐ **Tilting of head**	☐ **Redness/watering eyes**	☐ **Short attention span**

If you have questions, please contact:
Presciliana Olayo, Health Partnerships Director
O: 817-814-2813 | e-mail: presciliana.olayo@fwisd.org

*I have legal custody over my child named above and give permission to Alcon Children's Vision Center to share all of my child's vision exam results with Alcon Children's Vision Center partners for the purpose of providing prescription glasses. To qualify, your child must NOT have Medical Insurance that covers a vision exam and/or glasses, although your child may have Medicaid or CHIP. Your child must also participate in the free/reduced lunch program at school. Academic and behavioral performance measurements of my child **may also be shared with Alcon Children's Vision Center and its partners, to be used for research purposes to determine the effectiveness of this treatment and to publish results of the research. No publications will contain any personally identifiable information about your child. This information may be shared with the following:** My child's school nurse, Alcon Foundation, Alcon Children's Vision Center, and their respective partners and/or researchers.

****Dilation will enlarge the pupil, allowing the doctor to visualize the back of the eye better. Side effects include blurry vision, sensitivity to light, and enlarged pupils**, which may last a few hours. In refusing to have my eyes / my child's eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.

***I further give permission to Alcon Children's Vision Center, Alcon Foundation, and its founder and supporter, Alcon Vision, LLC, to take and use photos, videos, or recordings of my child's participation in the vision exam and related activities, in any printed or multimedia presentations, social media, radio, television, websites or in any other **distribution media for any lawful purpose. This includes but is not limited to national marketing purposes.** I agree that I will make no monetary or other claim against Alcon Children's Vision Center, The Alcon Foundation, or Alcon Vision, LLC for this release.

For School Nurse or Administrator Only

Right Eye Acuity: _____ **Left Eye Acuity:** _____ **With Glasses:** ____ **Screening Results:** _____

Date: _____ **Provider:**_____ **Instrument:** _____

School Name: _____ **Grade:** _____ **Teacher:** _____