Free Vision Exam Permission Slip

Alcon

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: _____

School Nurse/Staff
Place address label with student information, if available HERE

Student Ethnicity: ☐ **Hispanic / Latino** ☐ **Asian** ☐ **Black** ☐ **White** ☐ **American Indian / Native Alaskan**

☐ **Native Hawaiian / Pacific Islander** ☐ **Two or More Races**

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**

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

Is your child performing: ☐ **Below grade level** ☐ **At grade level** ☐ **Above grade level**

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

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

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

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

Parent/Guardian Signature: _____ Date: _____

By signing, I give permission for my child to get a vision exam.*

If you have questions, please contact:
Presciliana Olayo, Vision Care Services Coordinator
O: 817-814-2813 | e-mail: presciliana.olayo@fwisd.org

*I have legal custody over my child named above and give permission to share all of my child's vision exam results with Alcon Foundation and their 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 collected, shared with Alcon Foundations 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. **Additionally, I acknowledge and agree that, due to the nature of the clinic and services offered by Alcon Children's Vision Program, social distancing of 6 feet per person among children and clinic staff / doctors in a vision clinic setting is not possible. I fully understand both the known and potential dangers of utilizing the facilities and services of Alcon's Children's Vision Program and acknowledge that participating children may, despite Alcon's Children's Vision Program's reasonable efforts to mitigate such dangers, result in exposure to COVID-19, which could result in quarantine requirements, serious illness, disability, and / or death.**

****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 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 understand that my child's first name may be used in such marketing materials. I agree** that I will make no monetary or other claim against Alcon Foundation or Alcon Vision, LLC for this release.

For School Nurse or Administrator Only

Right Eye Acuity: **Screening Results:** **School Name:**

Left Eye Acuity: **With Glasses:** **Grade:** **Teacher:**