Colorado River Indian Tribes Eyeglass Clinic
Contact Information Form

Contact Name: _____

Primary Phone: (h) _____ **(c)** _____

(w) _____

E-Mail: _____

Additional participants that may be contacted with this information:

Name(s): _____

_____

_____

_____

_____

Please return your completed form to CRIT Office of the Attorney General/Prosecutors Office, 26600 Mohave Rd, Parker, AZ 85344; fax (928) 669-5675; or via email at ejames@critdoj.com

TO: Parents/Guardians of Students Attending _____
SCHOOL OR DISTRICT

FROM: _____
NAME OF SCHOOL ADMINISTRATOR / NURSE / HEALTH COORDINATOR

TOPIC: Permission for Your Student to Receive Free Vision Care

DATE: ____ / ____ / ____

Based on their vision screening results, your student is being referred to receive a free eye exam and glasses (if needed) during a OneSight Vision Clinic that will take place during regular school hours on

_____ **at** _____.
DATES *LOCATION*

_____is pleased to be able to provide these free services
SCHOOL OR DISTRICT
to students in conjunction with OneSight, a leading vision care nonprofit, which provides a comprehensive eye exam and stylish glasses (if needed).

Please read the following information and return the completed vision care consent forms based on your decision to allow your student to participate in the vision clinic.

Completed forms are due back to_____**by**_____.
LOCATION *DATE*

Your child will be supervised at all times by school staff and will receive a copy of their vision exam results.

If you have any questions, please contact_____
NAME
at_____and_____.
EMAIL *PHONE*

Thank you!

DID YOU KNOW?

80% of what children learn is visually processed, yet one in four students in the U.S. has an undiagnosed vision problem affecting their ability to see and learn in school. An eye exam and glasses (if needed) can help students achieve better learning through better vision.

OneSight

CONSENT FORM FOR VISION CARE SERVICES

SCHOOL SECTION: This information is completed by the school nurse or health coordinator.

Student ID: _____ Student Name: _____ DOB: ____ / ____ / ____

School: _____ Grade: _____

Date of Eye Exam: ____ / ____ / ____ Appointment Time: _____ Location: _____

PARENT NOTE: Your student will be at the vision clinic for approximately 2-4 hours. Please make arrangements for your child to have any necessary medications and/or food available on their assigned clinic day.

PARENT SECTION: I, _____ parent/guardian of, _____
Print Parent's/Guardian's Name *Print Child's Name*

give my permission for my child to receive a free eye exam and glasses, if needed, on the above date and time at the OneSight Vision Clinic at the location described above. I understand that in order to provide vision services, OneSight will need access to my child's confidential vision health care records maintained by the District. OneSight agrees to maintain the confidentiality of these student vision records and will not release any information personally identifying my child to any third party.

SIGN HERE _____ _____
PARENT/GUARDIAN SIGNATURE *DATE*

By signing below, acknowledgement is given of receipt of OneSight's ***Notice of Privacy Practices.***

SIGN HERE _____ _____
PARENT/GUARDIAN SIGNATURE *DATE*

1-A. Waiver of Dilated Fundus Exam-*see next page for details*

√ CHECK BOX ☐ ***I DO*** ☐ ***DO NOT*** - give my permission for the optometrist to perform a dilated fundus exam during the examination process at the OneSight Vision Clinic.

1-B. Permission to Photograph Student-*see next page for details*

√ CHECK BOX ☐ ***I DO*** ☐ ***DO NOT*** - give my permission for my child to be filmed or photographed and understand that my decision will not affect whether my child receives an eye exam or glasses at this Clinic.

Release of Liability *I release and discharge from any and all claims, demands and liability arising out of this event or any use granted herein the officers, directors, employees, agents, affiliates, and/or assigns of the following groups: District personnel; the independent optometrist(s) who perform the eye exam; any co-sponsoring agency; OneSight, and Luxottica Group, S.p.A.*

SIGN HERE _____ _____
PARENT/GUARDIAN SIGNATURE *DATE*

OneSight

IMPORTANT! PARENTS PLEASE FILL IN

CHILD'S HEALTH HISTORY

Student Information & Health History

In order to help facilitate the eye exam, the parent or guardian must complete this brief health history for the child named on previous page:

Does your child or any immediate family member (parent, grandparents, and sibling) have any of the following:

Diabetes:	☐ Yes Who: _____	☐ No
Glaucoma:	☐ Yes Who: _____	☐ No
High Blood Pressure:	☐ Yes Who: _____	☐ No
Does your child have any known allergies?	☐ Yes, please list: _____	☐ No
Is your child currently taking any medication?	☐ Yes, please list: _____	☐ No
Does your child currently wear glasses?	☐ Yes ☐ No	
Has your child ever worn glasses?	☐ Yes ☐ No	

Please list any known problems or symptoms your child has in regards to his/her vision and/or eye health:

_____

_____

_____

Explanation Section 1-A** (from previous page)-**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, which may make reading difficult.

Explanation Section 1-B** (from previous page)-**Permission to Photograph Student

This event may be photographed or filmed for use in communications and/or news media coverage relating to the OneSight Vision Clinic and its partners.