Parent Consent Form

Eye Exams at School!

1 in 4 children has vision issues.

Your child's school is offering comprehensive medical eye exams through 2020 On-site this school year!
2020 On-site will bill your insurance directly, you do not need to worry about co-pays or bills! If your child needs glasses, they will be fitted and glasses will be shipped to their school at no cost to you.

Eye Exams and glasses are **100% covered by MassHealth.**

No insurance? No problem, we will see your child and provide them with glasses if necessary.

Yes. I would like my child to get an eye exam.

All information must be complete.

MassHealth ID Number:

INSURANCE INFO REQUIRED**

Other Insurance Number: Insurance Name: Subscriber Name: Subscriber DOB:

Child's First Name Last Name Address: Street City State Zip

School Name Home Phone # Work Phone # DOB (MM/DD/YY) Gender

MEDICAL HISTORY *(Circle or complete all of the following information)*

1. In the past year, has your child received an eye exam from an eye doctor? YES NO
   If yes, what is the date of their last exam? _____

2. RECENT EYE SYMPTOMS (Circle all that apply).
   - Eye pain/sore eyes
   - Double vision
   - Eyelids droop
   - Blurred vision
   - Tired eyes
   - Lazy eye
   - Crossed/wandering eyes
   - Change in school performance
   - Itchy eyes
   - Red eyes
   - Light sensitivity
   - Bumping into things
   - Loss of vision
   - Headaches
   - Watering

3. HISTORY OF EYE PROBLEMS (Circle all that apply).
   - Glasses
   - Contact Lenses
   - Cataracts
   - Patching
   - Glaucoma

   Eye Injury, please explain: _____
   Eye Surgery, please explain: _____
   Other, please explain: _____
   _____

4. MEDICAL HISTORY (Circle or complete).
   - All Normal

   Please list any active medical problems: _____
   _____
   _____

5. OTHER MEDICAL CONDITIONS (Circle all that apply).
   - All Normal
   - Breathing Problems
   - Frequent Ear Infections
   - Attention Deficit Disorder
   - Neurological problems
   - Fever or weight loss
   - Heart Problems

   Other serious illness or symptoms: _____
   _____

6. MEDICATIONS (List all that apply).
   _____
   _____

7. OTHER CONCERNS: _____
   _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: By my signature below, I hereby acknowledge that I have received a copy of 2020's "Notice of Privacy Practices".

CONSENT TO TREAT: By my signature below, I hereby voluntarily consent to the examination and treatment of my child by 2020 doctors. I understand that giving my consent will allow 2020 to perform an eye exam which may include dilation of the eyes if deemed necessary by the doctor and may include other related diagnostic procedures and treatments as necessary in the judgment of the 2020 doctors. I acknowledge that the practice of optometry is not an exact science and that no guarantees have been or can be made to me as a result of such procedures and treatments for my child.

2020 OD Review: _____ Date: _____

CONSENT TO DILATE, IF NECESSARY:
In some instances, as part of a comprehensive eye examination, eye drops may be used that will temporarily relax the eye, making the pupils large and preventing the ability to focus on near objects. There may be some mild stinging for a few seconds when the drops are administered. If drops are administered, the pupils will remain large for approximately six hours. These drops are routinely used in eye exams of babies and children, and can be standard eye care procedures in a doctor's office for an eye exam although are not used in all cases. By my signature below, I hereby voluntarily consent to dilation of my child's eyes, if necessary, for this exam.

CONSENT TO DISCLOSE MY CHILD'S GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize 2020 to: (i) share results of my child's exam with his/her school nurse; (ii) release any information, including medical information, so that 2020 can treat my child, seek payment from third parties for such treatment, and generally carry on the health care operations of 2020 (e.g., quality assurance); (iii) disclose my child's medical information to insurers and providers outside of 2020 when necessary for purposes of my child's treatment, payment for that treatment, and for their health care operations; and (iv) communicate with me by phone (using the numbers listed above) and to disclose my child's general health information on my home answering machine/voicemail and on my cell phone voicemail, and to the following family (e.g., spouse, children) and friends (you may leave this line blank if you do not wish to name family/friends who can receive your child's general health information): _____ _____.

MY FINANCIAL OBLIGATIONS: I assign all medical benefits to which I am entitled to 2020. I agree that I am responsible for any co-payments or deductibles as stated in any Explanation of Benefits (co-pays and deductibles do not apply to MassHealth patient's under the age of 18). To the best of my knowledge all of the below information is true and accurate.

I have read and understand the eye program and I consent to have my child participate:

Parent/Gaurdian Signature: _____

Print Name: _____

Cell Phone #: _____

Email address: _____

Relationship to child: _____

Date: _____

SIGNATURE REQUIRED