AGELESS
EYE CARE

Dear Parent/Guardian,

Good vision is important for success in school. We are pleased that Ageless Eye Care will be serving our School District this year!

Ageless Eye Care will provide eye exams and glasses (if needed) at **NO COST** to your child. If the student does not have insurance, the vision exam and one pair of eyeglasses are provided at no cost to the family. If available, health insurance will be billed.

If a student requires a replacement pair of glasses, they might be available at a minimal fee- Inquire at the time of order. Replacement glasses will need to be picked up from our office, at which time payment will be due if a fee applies.

Below are reasons why your child may need an eye exam:

- My child is entering kindergarten
- My child is entering Illinois schools for the first time at any grade level
- My child failed the vision screening
- My child has an IEP
- My child's teacher recommended they receive an eye exam
- My child experiences any of the following:
  - Squinting
  - Tilting the head
  - Sitting too close to the television
  - Losing place while reading
  - Rubbing eyes
  - Excessive tearing or headaches

A completed and signed consent form is required to give your child an eye exam. Please read the attached consent and ask about anything that you do not understand. We will be happy to explain it.

Please remember to:

- **Sign the signature line.**
- Complete the last page with your child's medical history.
- Return the form to your child's school **as soon as possible –** Your child must have a signed consent form to receive services.

After the eye exam, if your child requires glasses, an optician will help your child select frames. Glasses will be delivered within 4 weeks to the school. If further eye care is indicated, a referral will be provided.

If you have questions, please contact _____

Sincerely,

Ageless Eye Care
Vision Services Consent Form

Your child has failed a vision screening test performed at school or was recommended for a comprehensive eye exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional. Please fill out this consent for your child to receive the eye exam.

Patient Information

Child's FULL Legal Name _____
First Name Middle Name Last Name

Sex: ☐ Male ☐ Female Age _____ Birth Date _____

Parent/Guardian's Name _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Does your child have Medicaid?

[ ]Yes [ ]No

Does your child have any of the following insurance plans?

[ ]BlueCross [ ]County Care [ ]Harmony [ ]Illinicare [ ]Meridian [ ]Molina [ ]NextLevel [ ]Other

Medicaid ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ Member ID: _____

As part of your child's eye exam, eye drops will be used for the purpose of dilating his/her eyes. These drops are an important part of an eye exam because they widen the pupil so the doctor can check the health of the eye. Temporary effects of these eye drops may include blurred vision and sensitivity to light, both of which could restrict your child's mobility, making it unsafe for him/her to travel unassisted or to operate a vehicle for the rest of the day.

I hereby give my consent for my child to be examined by the doctors of Ageless Eye Care for an eye exam and prescription eyeglasses. This consent does not authorize any treatments or service beyond what is stated. I understand that the Provider will bill the Illinois Medicaid or any other currently applicable insurance (including Managed Care Organizations) for any reimbursable services and/or materials. I understand my consent will be valid for one year from the date of signature. I have read the above information and have had the opportunity to have my questions answered.

Parent/Guardian Signature: _____ **Date:** _____

If you do NOT want your child to receive the following services, please check the appropriate box. Please note services will be performed unless indicated otherwise.

☐ At this time I DO NOT consent for my child's eyes to be dilated

***Please sign and date the signature line. Complete the medical history on reverse side of this form. **

AGELESS EYE CARE

Student Medical History Form

Please Print:
Student's Name:_____ School Name: _____

Student's Date of last Eye Exam: _____ Does your child currently wear glasses or contacts? ☐ Yes ☐ No

Does your child have any of the following conditions: (Check all that apply)

☐ Asthma	☐ Behavioral problems	☐ Attention Deficit Disorder	☐ Glaucoma
☐ Neurological problems	☐ Endocrine problems	☐ High Blood Pressure	☐ Musculoskeletal problems
☐ Heart Disease	☐ Mental Health illness	☐ Gastrointestinal problems	☐ Genitourinary problems
☐ Hearing/Ear problems	☐ Diabetes	☐ Other Condition _____	

Is your child taking any medications? ☐No ☐Yes
List medications:

_____

_____

Does your child have allergies? ☐No ☐Yes
List allergies:

_____

_____

Does your child use eye drops? ☐No ☐Yes
List eye drops:

_____

_____

Has your child ever had eye surgery? ☐No ☐Yes
If yes, please explain:

_____

_____

Has s/he had any of the following?

Vision Therapy	☐ No	☐Yes	Eye Injury	☐ No	☐Yes	Trouble finishing work	☐ No	☐Yes
Eye patch	☐ No	☐Yes	Eye Infection	☐ No	☐Yes	Lack of confidence	☐ No	☐Yes
Eye Surgery	☐ No	☐Yes	Itching/Burning	☐ No	☐Yes	Difficulty sitting still	☐ No	☐Yes
Pain in eyes	☐ No	☐Yes	Eye Discharge	☐ No	☐Yes	Avoids reading/writing	☐ No	☐Yes
Difficulty Tracking	☐ No	☐Yes	Tearing/Watering	☐ No	☐Yes	Difficulty paying attention	☐ No	☐Yes
Lazy/Wandering Eye	☐ No	☐Yes	Light sensitivity	☐ No	☐Yes	Reads below grade level	☐ No	☐Yes
Blurred/Double Vision	☐ No	☐Yes	Redness	☐ No	☐Yes	Poor handwriting	☐ No	☐Yes
Loses place while reading	☐ No	☐Yes	Drooping Lid	☐ No	☐Yes	Frustrates easily	☐ No	☐Yes

Other_____

Does your child have an IEP (Individualized Education Plan)? ☐ No ☐ Yes

Is the child performing at: ☐ above grade level ☐ grade level ☐ below grade level

If below grade level, please select the class (Check all that apply)
☐ Reading ☐ Writing ☐ Math ☐ Social Studies ☐ Other_____

Is the child currently receiving any of the **services** below? (Check all that apply)
☐ Special Education ☐ Tutoring ☐ Speech Therapy ☐ Occupational Therapy (OT) ☐ Physical Therapy (PT)

List any of your child's Hobbies or Special Interests: _____

Is there anything else you would like us to know about your child? _____

_____

_____

Does your child's immediate family member have any of the following? (Check all that apply and list the relationship to child)

☐ Wears glasses	☐ Wandering Eye	☐ Diabetes	☐ Cardiovascular problems
☐ Glaucoma	☐ Blindness	☐ Musculoskeletal problems	☐ Neurological problems
☐ Lazy eye	☐ Macular Degeneration	☐ Heart Disease	☐ Mental Health illness
☐ High Blood Pressure			