SOUTHERN COLLEGE OF OPTOMETRY
MOBILEYES
Community Vision Unit
memphisvision.org

Dear Parent/Guardian,

You are receiving this letter because your child failed the school vision screening, or has been encouraged by his/her school administrators to receive a full eye exam.

Who We Are

MobilEYES is owned and operated by Southern College of Optometry (SCO). We are a mobile vision clinic that provides full eye exams to children who:

Failed the school vision screening
Have vision-related problems which may include frequent headaches, squinting, low grades, poor conduct, low reading comprehension, or vision complaints

If your child is prescribed glasses, our MobilEYES staff will assist him or her with selecting a frame on the mobile unit, and our opticians will deliver the glasses to your child's school when they are complete. (Approximately 2-4 weeks)

What We Need

Please complete the attached consent form and medical history form fully and return to your child's teacher.

*****NOTE: Your child will not be able to receive an eye exam until we receive the completed forms. Dilation (which makes the pupil in the center of the eye larger using eye drops) is included, and very important to be able to check your child's overall eye health. However, if you prefer to opt out of dilation, you may do so on the consent form.**

If you have any questions, please contact our MobilEYES Project Coordinator, Stuart Turner, at 901.722.3274 or sturner@sco.edu. We look forward to serving your family, and care about your child's vision and eye health. Thank you!

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Consent for Treatment, Release of Information & Financial Responsibility

(Please Print)

Child's Full Name _____ Child's SS# _____ Date of Birth _____

Parent / Legal Guardian's Name _____ Relationship to Child _____ School/Facility _____

Address _____ City _____ Zip _____ Home Phone _____ Cell Phone _____

Child's Medical Insurance Type and Policy _____ Child's Vision Insurance Type and Policy _____

Parent / Insurance Subscriber's Date of Birth _____ Parent / Insurance Subscriber's SS# _____

Scope of Consent:

A **Vision Screening** is NOT a complete examination and ONLY assesses the child's ability to: **1)** see, both distance and near; and **2)** align the eyes. A **Comprehensive Eye Health & Vision Examination** includes, at a minimum, a complete evaluation of a child's ability to: **1)** see - both distance and near; **2)** align the eyes; **3)** perceive depth; **4)** perceive color; **5)** move the eyes appropriately; and **6)** focus the eyes at all distances. A thorough **7)** examination of the external structures of the eyes under magnification is conducted. Your child may have eye drops* to enlarge the pupils (i.e. dilate) and **8)** examine the health of internal structures of the eye. If glasses are needed; a **9)** prescription will be written. Contact Lenses may be an option but WILL NOT be prescribed without the Parent/ Legal Guardian present AND participating in education about the care and handling of lenses.

I, the above documented Parent/Legal Guardian, **request** **Vision Screening** and/or **Examination** AND authorize such Services, any Treatment, Management and/or Referrals deemed appropriate by the optometric physicians of Southern College of Optometry (SCO) including the use of non-physician extenders (i.e. interns/students) in an educational capacity.

_____
Initials

In providing Services to your child, we create, and store, personally identifiable health information about your child. We are committed to protecting the privacy of this information in accordance with all prevailing state and federal regulations. **I acknowledge** that SCO may use any information obtained from these services in: 1) the care of my child; 2) the education of new doctors; and 3) research purposes, provided that my child's identity, rights & responsibilities will be protected according to the ***Notice of Confidentiality & Privacy Policies*** in place at SCO. A copy will be provided to me the day services are provided.

_____
Initials

Further, **I understand** that SCO will file a claim, with the insurance company indicated above, for any eligible Services provided and/or Materials supplied my child. **I grant** permission to release any information necessary for payment of any claims filed with any insurance company for which my child has coverage.

_____
Initials

I AM THE PARENT/LEGAL GAURDIAN OF THE ABOVE NAMED CHILD. **I HAVE PROVIDED ACCURATE INFORMATION, READ, UNDERSTAND AND AGREE TO EXAMINATION & TREATMENT** OF MY CHILD INCLUDING BILLING FOR SERVICES PROVIDED.

Parent's Signature _____ Date _____

Medical, Visual & School Performance History

Child's Full Name _____ Child's SS# _____ Date of Birth _____

Why have you requested a Vision Screening / Examination? _____

When was the last time your child received a full eye exam? _____

What are your child's specific problems / complaints? _____

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

Does your child have any medical allergies? ☐ Yes / ☐ No List: _____

What is the Drug Store you use? _____ Drug Store #: _____

Patient Ocular / Medical History	Yes / No
Does Child Wear Glasses?	☐ Yes ☐ No
Does Child Wear Contact Lenses?	☐ Yes ☐ No
Eye Injury	☐ Yes ☐ No
Loss of Vision/Blindness	☐ Yes ☐ No
Eye Turn	☐ Yes ☐ No
Lazy Eye	☐ Yes ☐ No
Red Eye/s/	☐ Yes ☐ No
Dry Eye/s/	☐ Yes ☐ No
Eye Infection	☐ Yes ☐ No
Retinal Disease	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No
Has the Child had Eye Surgery?	☐ Yes ☐ No
Has the Child had ANY Surgery?	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Sickle Cell Disease	☐ Yes ☐ No

Family Ocular / Medical	Yes / No / Who
Do Parents Wear Glasses?	☐ Yes ☐ No Who:
Do Parents Wear Contact Lenses?	☐ Yes ☐ No Who:
Eye Injury	☐ Yes ☐ No Who:
Loss of Vision/Blindness	☐ Yes ☐ No Who:
Eye Turn	☐ Yes ☐ No Who:
Lazy Eye	☐ Yes ☐ No Who:
Red Eye/s/	☐ Yes ☐ No Who:
Dry Eye/s/	☐ Yes ☐ No Who:
Eye Infection	☐ Yes ☐ No Who:
Retinal Disease	☐ Yes ☐ No Who:
Glaucoma	☐ Yes ☐ No Who:
Cataracts	☐ Yes ☐ No Who:
Macular Degeneration	☐ Yes ☐ No Who:
Has a Parent had Eye Surgery?	☐ Yes ☐ No Who:
Has a Parent had ANY Surgery?	☐ Yes ☐ No Who:
Diabetes	☐ Yes ☐ No Who:
High Blood Pressure	☐ Yes ☐ No Who:
Sickle Cell Disease	☐ Yes ☐ No Who:

School History & Performance	
Has Child been Held Back a Grade?	☐ Yes ☐ No
Has Child been Moved Ahead a Grade?	☐ Yes ☐ No
Is Child at Grade Level in Math?	☐ Yes ☐ No
Is Child Reading at Grade Level?	☐ Yes ☐ No
Headaches When Reading	☐ Yes ☐ No
Squints When Reading	☐ Yes ☐ No
Covers One Eye When Reading	☐ Yes ☐ No
Turns Head When Reading	☐ Yes ☐ No
Loses Place When Reading	☐ Yes ☐ No
Uses Finger to Read	☐ Yes ☐ No
Avoids Reading	☐ Yes ☐ No
Rubs Eyes Often	☐ Yes ☐ No
Headaches at end of School Day	☐ Yes ☐ No
Blurred Vision at end of School Day	☐ Yes ☐ No
How many hrs/day is a Computer Used?	
What are your Child's non-school Hobbies?	

Patient Review of Health	Yes / No / Who
Fever, Sleep Problems, Weight Loss/Gain	☐ Yes ☐ No Who:
Diabetes, High Blood Pressure, Stroke	☐ Yes ☐ No Who:
Allergies, Sinus Problems	☐ Yes ☐ No Who:
Asthma, Bronchitis, Emphysema	☐ Yes ☐ No Who:
Diarrhea, Constipation	☐ Yes ☐ No Who:
Kidney / Bladder Problems	☐ Yes ☐ No Who:
Arthritis, Muscle/Joint Pain	☐ Yes ☐ No Who:
Rash, Hives, Dryness of Skin	☐ Yes ☐ No Who:
Headaches, Seizures	☐ Yes ☐ No Who:
Emotional / Mental Problems	☐ Yes ☐ No Who:
Thyroid, Growth Problems	☐ Yes ☐ No Who:
Bleeding, Anemia, Sickle Cell	☐ Yes ☐ No Who:
Allergy	☐ Yes ☐ No Who:
Does anyone in the home Smoke?	☐ Yes ☐ No Who:
Does anyone in the home Drink Alcohol?	☐ Yes ☐ No Who:
Does anyone in the home use Illegal Drugs?	☐ Yes ☐ No Who:
How Tall is your Child? _____	Weight: _____

*NOTE: I understand without using eye drops, a thorough examination cannot be conducted and important information about my child's eye and/or general health may not be visible to the Doctor and another examination may need to be conducted.

I do NOT want my child's eyes dilated. _____
Initials

ME-105 (10-18)