NG #:	
Exam:	

Cherry Health
Comprehensive. Quality. *Healthcare.*

School Vision Program
2020/2021

School:	**DISCOVERY**
Teacher:	

This consent is for vision services to be completed at school. These services include a complete eye exam including dilation, using eye drops; dilation can last 6-24 hours and may include blurry vision and sensitivity to light. If glasses are needed, your child may select frames with the help from Cherry Health staff and will be delivered to school. These services will be at no charge to you, however, if you have insurance we accept or Medicaid, these carriers will be billed as payment in full.

Please complete all of the information below if you would like your child seen for vision services. If not, please only print your child's name and sign at the bottom of the form.

Child's Legal Name	Date of Birth	Age	☐ Male ☐ Female	Language spoken at home

Address	City	Zip Code

Mother's / Guardian Name	Date of Birth	Phone #	Email

Father's / Guardian Name	Date of Birth	Phone #	Email

Number in Household	**Household Income Per Year**	**Which group describes you best?**		
		☐ American Indian/Alaskan Native	☐ More than one group	☐ White
		☐ Asian	☐ Native Hawaiian	☐ Latino or Hispanic
		☐ Black/African American	☐ Other Pacific Islander	☐ Not Latino or Hispanic

Medicaid / Vision Insurance Information

Does your child have Medicaid? ☐ Yes ☐ No	Child's Medicaid #	Other Vision Insurance & Policy #

Patient Medical History

Headaches? ☐ Yes ☐ No	Migraines? ☐ Yes ☐ No	If Yes, how often do they occur? (circle): Daily Weekly Monthly

Any other medical problems?
(heart, lungs,diabetes, neuro, muscular, blood other):

Allergies to Medication? ☐ Yes ☐ No	Seasonal Allergies? ☐ Yes ☐ No	List other allergies:

Current medications
your child is taking:

Has your child ever worn glasses? ☐ Yes ☐ No	Date of last eye exam with a doctor:
Does your child currently wear glasses? ☐ Yes ☐ No	How old are the glasses?

Please list any vision
problems:

Any health problems with parents or siblings? ☐ Yes ☐ No	If so, please explain:

By signing and *completing* this form, I agree I am the legal guardian and consent for my child to receive vision services. This also includes consent for Cherry Health staff members to share my child's information with relevant school staff.

Parent / Guardian Signature	**Date**

Effective 2020/2021 school year