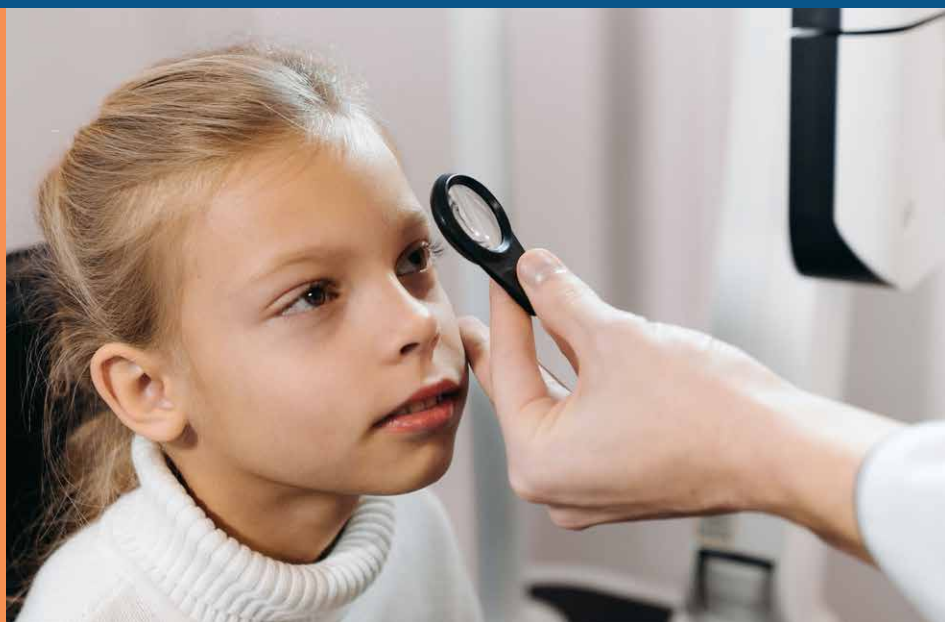
HEALTHY CPS
— OFFICE OF STUDENT HEALTH & WELLNESS —

Vision Program: Schedule An Eye Exam

Chicago Public Schools has partnered with Illinois Eye Institute at Princeton and Tropical Optical to provide vision exams for CPS students.

Seven locations throughout the city have been provided for your convenience. Please review the list of vision service locations listed below.

You may select any of the locations listed or your own healthcare provider.



Tropical Optical

Select from a location below

Families can walk-in from 10:30 a.m. – 2:00 p.m. or call **(773) 762-5662** for additional appointment hours.

For children 5yr through high school.

Tropical Optical Locations

6141 West Cermak Road, Cicero, IL 60804

3624 West 26th Street, Chicago, IL 60623

2250 South 49th Avenue, Cicero, IL 60804

3213 West 47th Place, Chicago, IL 60632

2767 North Milwaukee Avenue, Chicago, IL 60647

9137 South Commercial Avenue, Chicago, IL 60617

Illinois Eye Institute (IEI)

Lewenson Center
3241 South Michigan Avenue, Chicago, IL 60616

Families can walk-in Monday to Friday from 8:30 a.m. – 9:30 a.m.

Ages 3 through high school.

For afternoon appointments call (312) 949-7990.

Ages 3 through high school.

For more information about the CPS Vision Program, please contact **(773) 535-1968** or email **oshw@cps.edu.**

Chicago Public Schools

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Office of Student Health and Wellness
42 W. Madison St., Chicago, IL 60602

Dear Parent/Guardian,

Did you know one in four children have an undiagnosed vision problem that may affect their ability to learn? Every child needs an annual vision exam, especially if any of the following apply to your child:

- My child is entering kindergarten
- My child has never received a vision exam
- My child is entering Illinois schools for the first time at any grade level
- My child failed the school vision screening
- My child has an IEP
- My child's teacher recommended they receive an eye exam
- My child is performing below grade level
- My child experiences any of the following:
  - Squinting
  - Blurred or double vision
  - Tilting of the head
  - Holding reading materials close to the face
  - Losing place while reading
  - Rubbing eyes
  - Excessive tearing or headaches

All kindergarten students and any child entering the State of Illinois for the first time must have a vision exam per state law by October 15.

- **If your child has a private eye doctor**, please have your child's eye doctor complete the State of Illinois Eye Examination Report on page 16.
- **If your child does not have a private eye doctor**, your child is eligible to participate in the CPS Vision Program. Through this program, your child will receive eye exams. If your child requires glasses, an optician will help your child select the frame, and glasses will be delivered to your child's school within four weeks. Students who receive glasses are eligible for replacement glasses due to loss or damage for up to 12 months from the initial eye exam. Private vision insurance or government insurance such as Medicaid, Medicare or any Managed Care Organization will be billed, if available. If a student does not have vision insurance, services are provided at no cost to the family.

To enroll your child in the CPS Vision Exam Program, please complete the Vision Services Consent Form on page 13 and the Student Medical History Form on page 14.

If you have any questions, please contact Katheryn Stafford-Hudson, Program Manager, at (773) 535-8675 or kgstafford-h@cps.edu, or the CPS Vision Team at Princeton (773) 535-1968.

Sincerely,

FPO SIGNATURE

Tashunda Green-Shelton
Deputy Chief

Vision Services Consent, Release of Liability, and Authorization Form

Chicago Public Schools

Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible.

please print or type:

STUDENT LAST NAME	**FIRST NAME**		**MIDDLE NAME**	
GENDER	**STUDENT DATE OF BIRTH**	**SCHOOL NAME**		
STUDENT ID #	**GRADE**		**ROOM #**	
PARENT/GUARDIAN NAME		**PARENT EMAIL ADDRESS**		
PHONE	**HOME ADDRESS** (include unit number if applicable)	**CITY**	**STATE**	**ZIP**
MEDICAID/MEDICAL CARD/ALLKIDS RECIPIENT #		**RACE/ETHNICITY**		**DATE OF BIRTH**
PRIVATE VISION INSURANCE	**CARDHOLDER NAME**		**GROUP ID#**	**ID#**
PRIVATE MEDICAL INSURANCE	**CARDHOLDER NAME**		**GROUP ID#**	**ID#**

As the parent/guardian of the above name student, I understand that my child will receive a comprehensive eye exam to determine if he/she needs prescription glasses or other treatment by a vision care professional (Provider).

I further understand that this eye exam may be performed by an Optometrist; an Ophthalmologist; qualified specialist; or an intern, a resident, or a student clinician or technician under the supervision of an Optometrist, Ophthalmologist, or another qualified specialist, and I consent to have my child receive a vision exam and/or treatment.

I further understand that neither the school nor the Board of Education of the City of Chicago (Board) are supervising or overseeing any services (such as an eye exam) or materials (such as eye glasses) that may be furnished to my child and that the Board and the school will have no responsibility for the quality of any such services or materials.

In consideration for the services and materials that my child will receive, I hereby agree to indemnify, release and hold harmless, and defend the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, and representatives, and the Board and its members, trustees, agents, officers, contractors, volunteers, representatives, and employees from any liability which may accrue to me or my child, for any and all claims, losses, injuries, damages to me or my child, both known and unknown, foreseen and unforeseen, arising in connection with my child's receipt of services and materials, whether or not said claims, losses, injuries, damages, or liabilities result in whole or in part from the negligence of the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the Board, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives. I further agree to release and hold harmless the Providers and Co-Sponsors, their employees, officers, volunteers, agents and representatives from and against any and all claims, demands, actions, complaints, suits or other forms of liability that will arise out of or by reason of, or be caused by any performance of services provided by such Providers or the quality of the eyeglasses or any other materials furnished by them under the Program, unless attributed to their willful or wanton misconduct. In the event that one provision of this form is held unenforceable, that provision shall be severed and the remainder of the form shall remain in effect.

I understand that the Provider will bill any government or private insurance Illinois Department of Healthcare and Family Services (HFS) or any other currently applicable private insurance for any reimbursable services and/or materials.

If you DO NOT want your child to receive the following services, please check the appropriate box.

If your child has an allergy, please consult your primary care physician before selecting dilation.

I understand that as part of this eye exam, pharmaceutical agents (eye drops) will be used for the purpose of dilating my child's eyes. These drops are an important part of an eye exam to allow the Provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops include blurred vision and sensitivity to light, both of which could restrict my child's mobility making it unsafe for him/her to travel unassisted or to operate a vehicle for the rest of the day.

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

I understand that by refusing dilation I may limit the doctor's ability to detect and treat certain conditions.

Please note services will be performed unless indicated otherwise.

I understand that my child may be selected to be photographed, video taped, audio taped or interviewed as part of promotional documentation for the Vision Program. I consent to the use of my child's photograph, voice or likeness by the Board or the Provider or CDPH, but not the use of my child's last name. I understand there is no compensation, monies, or reimbursement for my child's participation.

☐ **At this time I DO NOT consent for my child to be photographed or interviewed.**

By signing below, I understand that I am giving my authorization to the City of Chicago Department of Public Health (CDPH) and the Board of Education of the City of Chicago (Board) to release and furnish information regarding past vision screening data in my child's education record to Providers to ensure that the Providers can effectively provide services. I authorize the Providers to release and furnish reports to my child's school, including written and verbal reports concerning the results of any eye exam, for inclusion in my child's education record. I also authorize CDPH to release to the Board, my child's information, the date and type of vision services provided, whether my child was recommend for follow-up services, and other information the State of Illinois requests the Board to report. I understand that such records will be subject to the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinois Department of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization.

*****Please sign and date both signature lines. Complete the medical history on the second page of this form.*****

This authorization is valid for one year. I may revoke this authorization at any time by sending written notification to CDPH, my child's school, or the Board Office of Student Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

Parent/Guardian Signature **Date**

I hereby give my consent for this child to be examined by a Provider for an eye exam and prescription eyeglasses, if prescribed during the eye exam. This consent does not authorize any treatments or service beyond what is stated. I understand my consent will be valid for one year from the date of signature.

Parent/Guardian Signature **Date**

Must have an original signature; an electronic signature is not acceptable.