Ohio Optometric Foundation
In-school eye exam program

Ohio Optometric Foundation
Confidential History

Parents or Guardians: Please complete every question on this form. Do not leave any question blank. You may write "not applicable," "N/A", "unknown" or "none" if a question does not apply to your child. This information is important to ensure a complete eye examination. **A completed form is required in order for your child to participate in this program.**

Child's name:	**Age:___ Birthdate:_____**
	Teacher name:
Parent/Guardian's Name:	**Grade:_____ School:_____**
	Home/Mobile Phone#:

Address:_____

Street address Apt# City State Zip

Is your child covered by Ohio Medicaid? (circle one) Yes No

Other Vision Insurance:_____ **Other Medical Insurance:**_____

Tell Us About Your Child's Vision and Eye Health History

What is the date of your child's last eye exam?_____ **Eye Doctor's name**_____

Please check any of the following problems your child is currently having:

- ☐ Distance vision is blurry
- ☐ Near vision is blurry
- ☐ Spots or Floaters
- ☐ Flashes of Light
- ☐ Headaches
- ☐ Double vision
- ☐ Watering
- ☐ Glare
- ☐ Eyestrain
- ☐ Itching
- ☐ Burning
- ☐ Eye pain

Please check any of the below if your child has ever had:

- ☐ Eye infection
- ☐ Eye Injury
- ☐ Patching or vision therapy
- ☐ An eye turn or a "lazy" eye
- ☐ Other eye problem:____
- ☐ Eye Surgery
- ☐ Cataracts
- ☐ Head injury

Tell Us About Your Child's Medical Health History

What is the date of your child's last physical exam?_____ Doctor's name_____

Check any of the below if your child has been diagnosed with any of the following:

- ☐ Developmental delay/disorder
- ☐ Behavioral disorder
- ☐ Diabetes
- ☐ Breathing problems (example: asthma)
- ☐ Heart problems
- ☐ Digestive system problems
- ☐ Thyroid disorder
- ☐ Blood disorder
- ☐ Neurologic disorder
- ☐ Skin disorder
- ☐ Bone/Muscle disorder
- ☐ Ear/Nose /Throat disorder
- ☐ My child does not have any medical health problems

Check any of the boxes below if anyone in **your child's immediate family** has been diagnosed with any of the following:

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachments/disorder
- ☐ Thyroid disorder
- ☐ Diabetes
- ☐ High Blood Pressure

List any medications your child is currently taking. (Include any inhalers, eye drops, or over the counter medications.) Write "none" if your child is not taking any medications.

_____

_____

List your child's medication allergies, food allergies, seasonal or environmental allergies below. Write "none" if your child has no known allergies.

_____

_____

Ohio Optometric Foundation
In-school eye exam program

PATIENT CONSENT FORM

I hereby consent to permit my child to receive a comprehensive or intermediate eye exam, and, if prescribed, lens and frame services through the Ohio Optometric Foundation.

A complete eye exam may include the use of dilating drops that will cause the pupils to enlarge. Dilation of the pupils will facilitate the determination of an accurate prescription for eyeglasses and will allow proper viewing of the inside of the eye. Temporary blurred vision that may last up to 24 hours and light sensitivity are typical side effects of dilating drops. Very rare complications may include an allergic reaction to the drop or an acute increase in intraocular pressure.

By signing this document, I am consenting to any and all procedures the Optometrist deems necessary to examine and treat my child and I understand that rare complications may arise.

I certify that I am of legal age and that I have read and understand this form, and that this form has been voluntarily executed on the date indicated below.

Student Name:_____
(print name please)

Parent/Guardian Name:_____
(print name please)

Parent/Guardian Signature: _____Date:_____

OR

Student Signature (if 18 years or older)_____Date:_____

About the Ohio Optometric Foundation
The Ohio Optometric Foundation is a 501(c)(3) nonprofit organization, whose mission is to improve the visual health and welfare of Ohio's citizens. The Ohio Optometric Foundation achieves its goals through programs that improve the vision and eye health of the citizens of Ohio; provide opportunities and resources for children and underserved individuals to obtain eye health care; and promote public awareness of the importance of a lifetime of comprehensive eye care.

Ohio Optometric Foundation Media Authorizations and Release

(Photo, Video, and Testimonial)

I hereby authorize the Ohio Optometric Foundation, and/or its representative(s) (the "Foundation"), to use, disclose, publish, copyright and/or otherwise make available my information, personal image, testimonial or other materials, in whole or in part, to the general public for purposes of community relations initiatives, event announcements and promotions, social media outreach, advertising, training activities, Foundation programs, and other communications activities, including putting this material on the Foundation's web page. This Authorization and Release covers all forms of media, including print, digital, and electronic media in every form and forum.

I understand that:

- This Authorization and Release has no expiration. A copy of this Authorization and Release is valid as the original. I hereby waive the right to inspect and/or approve the finished copy of any print, digital, or electronic media that may be produced using my information, image, testimonial or other materials or eventual use to which it might be applied.

- No money will ever be due to me from the Foundation or any source as a result of the publication, use, or disclosure of my information, personal image, testimonial or other materials that I have authorized to be used or disclosed by this Authorization and Release.

- I forever release and discharge Foundation from all claims and demands arising out of or in connection with any and all rights I may have or may have had in my information, personal image, testimonial or other materials that I have authorized to be used and disclosed in this Authorization and Release including, but not limited to, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights.

Personal Signature:

By signing below, I acknowledge this Authorization and Release is a voluntary contribution and that I have read this Authorization and Release carefully and fully understand it.

Signature:_____Date:_____

If Patient is a minor,

Parent/Guardian

Signature: _____ Date: _____

☐ I do not consent.

Signature: _____ Date: _____