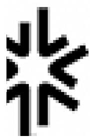

Southern College Of Optometry
1225 Madison Avenue, Memphis TN 38104
(901) 722-3378

Vision Screening Consent and Authorization Form

I understand that

- the data collected at this screening are preliminary only and are not conclusive;
- this screening was designed to detect only gross visual problems in the specific areas tested;
- passing this screening does not guarantee that my child does not require further eye or general health care;
- yearly eye examinations are recommended for my child regardless of the screening results; and
- the responsibility for proper follow-up relies only with me, not with any particular organization or individual.

I, the undersigned, request that a Vision Screening be performed on my child by Faculty, Residents and /or Student Interns of the Southern College of Optometry. I understand that I may be contacted by the Southern College of Optometry about the results of this vision screening.

I understand that the Southern College of Optometry has a Privacy Policy and that I am entitled to a copy of the policy, which I may obtain by contacting the Privacy Officer at the college.

I agree to allow the data from this screening exam and from any questions that appear on this form to be used in studies on vision conducted by the Southern College of Optometry, provided that any information that identifies me or my child is removed from the data.

I agree to participate in a study being conducted by the Southern College of Optometry about eye care following a vision screening. This study involves a routine phone call and/or email to determine if follow-up care was provided to those children who do not pass this screening.

I have read and understood these statements. This authorization is valid for 1 year after the date next to my signature below.

____ _________________________

Signature of parent / guardian *Date*

Child's name: __________________________________ Child's date of birth: ___________________

(please print)

School name: St. George's Independent School Teacher's name: _______________________

Home phone: __________________________________ Email: _______________________

RIGHTS

- I have a right to receive a copy of the Authorization
- I have the right to revoke this authorization at any time by submitting a written request, signed by the parent or legal guardian, to the Privacy Officer at the Southern College of Optometry. I am aware that my revocation is not effective to the extent that the person(s) I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
- I understand that if the person(s) authorized to receive this information is not a health plan or health care provider, the released information may be disclosed and would no longer be protected by the Privacy Rule in the Code of Federal Regulations.

A. Has your child had an eye exam by an eye care practitioner (not a pediatrician)? (Circle one): Yes No

  a. If Yes, by what type of provider?: 1. Optometrist (O.D.) 2. Ophthalmologist (M.D.) 3. Pediatric Ophthalmologist (M.D.) 4. Other (Please Specify): _______________________

  b. If No, what best describes the reason your child has not had an eye exam? (Circle one): 1. No sign/symptom of vision problems 2. Passed School Screening 3. Other (specify):_____________________

B. Does your child wear glasses or contact lenses? (Circle all that apply): No Glasses Contact Lenses

C. How is your child supposed to wear their vision correction? (Circle one): Full-time Near tasks Only Distance Only

D. When my child does not wear their correction at school it is because: forgot lost/broke dislike their correction

Other: ________________