hH half Helen
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CONSENT FOR VISION SERVICES I PLEASE COMPLETE & RETURN BY _____

half Helen Foundation is conducting a mobile vision clinic at your child's school. Should your child fail their school vision screening, a comprehensive eye exam will be performed onsite by a licensed optometrist. If determined necessary by the optometrist, your child will receive high-quality prescription glasses to correct their eyesight. **All services are provided at no cost to the family.**
To qualify for half Helen Foundation vision services, children must be between 5 – 18 years old on the day of the vision clinic and qualify for the Free/Reduced Price Lunch program.
PLEASE NOTE: Children who have Medicaid or CHIP are also eligible to receive vision services.

By signing below, I consent to my child receiving vision services from half Helen Foundation.
I *confirm that:*

- My child qualifies for vision services based on the eligible requirements listed above.
- I am the parent or legal guardian of the child named below.
- I have read and understand the information on this form and on the Parent Information Sheet provided.
- I give permission for my child to receive a vision screening and if needed, an eye exam and prescription glasses.
- I understand that my child may receive dilating eye drops during the eye exam.
- I authorize full disclosure of the results of my child's vision screening and eye exam to appropriate personnel at my child's school, school district health personnel and half Helen Foundation partners.
- I understand that I may remove this authorization in writing at any time, but that by doing so, I am also declining my child's participation from any services provided by half Helen Foundation.
- I understand that if there is an unauthorized disclosure, I may file a formal complaint with the United States Department of Health & Human Services.

CONSENT FOR MEDIA RELEASE: half Helen Foundation may take photos or videos of children participating in the program to be used in promotional material. If you provide your consent, these images may be used in print media, on websites or on social media websites at the discretion of half Helen Foundation. Media Release Consent is not required for participation in vision services.

☐	YES	I consent to photos or videos of my child being used by half Helen Foundation.
☐	NO	I do not consent to photos or videos of my child being used by half Helen Foundation.

YOUR SIGNATURE BELOW IS REQUIRED TO CONFIRM YOUR RESPONSE:

PARENT/GUARDIAN SIGNATURE			
PARENT/GUARDIAN NAME PRINTED			
DATE	_____/_____/_____	**PHONE #**	
EMAIL			

CHILD INFORMATION:

CHILD'S FIRST & LAST NAME PRINTED					
DATE OF BIRTH	_____/_____/_____	**AGE**		**GRADE**	
SCHOOL DISTRICT		**SCHOOL**			
TEACHER NAME					

MEDICAL HISTORY:

Has this child worn glasses?	___ Yes ___ No	**If yes – how long?**	____ years	**How old are current glasses?**	____ years

When was your child's last annual eye exam?	
Is there any history of family eye health problems? Describe.	
Does this child have any vision problems? Describe.	
Does this child have any medical issues? Describe.	
Please list ALL medications this child is currently taking.	