Family Health Care
Vision Outreach Program
1035 E. Wilcox Street, PO Box 746
White Cloud, MI 49349
231-689-7148 or 231-689-7123

School: _____

Teacher: _____

This consent is for **Vision** services to be completed at school. Please complete all information completely, circle **YES** or **NO,** signature is required and return to your child's teacher as soon as possible.

_____	____/____/____	_____	□ Male □Female
CHILD'S LEGAL NAME (PLEASE PRINT)	DATE OF BIRTH	AGE	
_____	_____	_____	
ADDRESS	CITY	ZIP CODE	
_____	____/____/____	_____	
MOTHER'S/GUARDIANS NAME (PLEASE PRINT)	DATE OF BIRTH	PHONE NUMBER	
_____	____/____/____	_____	
FATHER'S/GUARDIANS NAME (PLEASE PRINT)	DATE OF BIRTH	PHONE NUMBER	

VISION

You are giving consent for your child to have the following VISION SERVICES: Complete eye exam including dilation using eye drops. (Dilation can last from 6-24 hrs and may include blurry vision and sensitivity to light) If glasses are needed, I allow my child to select frames with help from vision staff and understand that glasses will be delivered to the child at school within a few weeks. This consent applies to any follow up vision appointments necessary throughout the school year and includes consent to share these results with relevant school staff.

Medicaid Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (10 digit number)

_____	_____
Name of INSURED PARENT	Name of VISION INSURANCE
_____	_____
Policy Number (May be subscribers Social Security Number)	Name of MEDICAL INSURANCE and POLICY NUMBER

YES or NO	_____	_____
CIRCLE ONE	PARENT/GUARDIAN SIGNATURE	DATE

PATIENT MEDICAL HISTORY

Allergies to medicine, seasonal allergies, etc.:_____

Current medications your child is taking: _____

Has your child ever worn glasses?◉Y or◉N

Date of last eye exam with an eye doctor: _____

Does your child currently wear glasses?○Y or○N

How old are the glasses? _____

Please list any vision problems:

Please circle YES/NO for your CHILD:

Asthma?	YES	NO	Diabetes?	YES	NO
Headaches?	YES	NO	Any smoking in the home?	YES	NO
Heart problems	YES	NO	Individual Education Plan (IEP)?	YES	NO

Other health problems:

Family Medical History

Any health problems with parents or siblings? Y or N If yes, please explain: _____

Blindness, glaucoma, or eye diseases with parents or siblings? Y or N If yes, please explain _____

*Services provided at the school will be billed the same as if they were performed in our office and will be billed directly to your insurance. If follow up treatment is needed you will be contacted by a Family Health Care staff member to schedule at the office. I understand that by circling YES and signing this form that I am the legal guardian and give consent for vision services.