Preserve Vision Screening Registration
Funded by Juvenile Welfare Board
(Please fill out both sides)

HOUSEHOLD INFORMATION

HOUSEHOLD Last Name:

____

Address: ____

Apartment / Unit #: ________________________

City: ____________________________ **Zip Code**: ______________

How did you hear about this program? ________________

____

Parent 1 / Contact 1: (_______) ________ - ______________

Parent 2 / Contact 2: (_______) ________ - ______________

Can you receive texts? __________**YES** __________**NO**

Parent's Email: ____

Number of Minor Children __________

Number of Adults __________

Household Income (before taxes) ______________

Household Arrangement (select one):

- _______Single Parent-Mother Head of Household
- _______ Single Parent-Father Head of Household
- _______Dual Parent (both parents) - Married
- _______ Dual Parent-Non Married Mother Head of Household
- _______Dual Parent-Non Married Father Head of Household
- _______ Other-Relative/Kinship Care Male Head of Household
- _______ Other-Relative/Kinship Care Female Head of Household
- _______ Other-Relative/Kinship Care-Married
- _______ Other-Non Relative
- _______No Dependent-Married
- _______No Dependents-Couple, Non-Married
- _______No Dependents-Single Female
- _______No Dependents-Single Male

STUDENT INFORMATION

Pinellas Student ID ______________________________
(If Applicable)

Student First Name ______________________________

Student Last Name ______________________________

Date of Birth _____/______/ _______ **Sex:** M / F

Relationship to Head of Household (select one):

- ___ Biological son or daughter
- ___ Adopted son or daughter
- ___ Stepson or stepdaughter
- ___ Brother or sister
- ___ Other relative
- ___ Grandchild
- ___ Self
- ___Son-in-law or daughter-in-law
- ___Other non-relative
- ___Roomer or Boarder
- ___Housemate or roommate
- ___Unmarried partner
- ___Spouse

Race (select one):

- ___ White
- ___ Black, African American
- ___ Native Hawaiian
- ___ American Indian or Alaska Native
- ___ Guamanian or Chamorro
- ___ Chinese
- ___ Other Asian (Hmong, Laotian, Thai, Pakistani, Cambodian, etc.)
- ___ Other Pacific Islander (Fijian Tongan, etc)
- ___Multiracial
- ___Vietnamese
- ___Asian Indian
- ___Samoan
- ___Filipino
- ___Japanese
- ___Korean
- ___Some other race

Student SSN: ______________________________

Is Student Pregnant? (circle one): Yes / No

Ethnicity (select one):

- ___ Yes, Mexican, Mexican American, Chicano
- ___Yes, Puerto Rican
- ___ Yes, Cuban
- ___ Yes, another Hispanic, Latino or Spanish Origin
- ___No, Not of Hispanic, Latino or Spanish Origin

Grade (select one):

- ___Age 0-5, attending Child Care Center
- ___Age 0-5, attending Family Day Care Center
- ___Age 0-5, not attending Center or Family Care Home
- ___ Voluntary Pre-Kindergarten (VPK)
- ___ Kindergarten
- ___ 1st Grade
- ___2nd Grade
- ___3rd Grade
- ___4th Grade
- ___5th Grade
- ___6th Grade
- ___7th Grade
- ___8th Grade
- ___9th Grade
- ___10th Grade
- ___11th Grade
- ___12th Grade
- ___High School Graduate
- ___GED or High School Equivalent
- ___School Age, not currently enrolled

School Name: ______________________________

Key - PDNP = Parent Did Not Provide

PLEASE CONTINUE TO NEXT PAGE FOR SIGNATURE

Preserve Vision Screening Registration
(continued)

Juvenile Welfare Board

Student Name: ____

Pinellas Student ID:____

Risk Assessment:

Does your child have Vision insurance? _____YES _____NO
Does your child have Medicaid? _____YES _____NO
Please circle child's Medicaid provider:
Amerigroup/Simply Health Staywell Prestige
Other Type of Medicaid:________________________________
Does your child have private insurance? _____YES _____NO
If YES, type:________________________________
Does your child wear glasses / contacts? _____YES _____NO
Does he/she have them with him/her? _____YES _____NO
Does he/she wear them for (circle one):
Distance Vision / Close-up Vision / Both
Does your child have a valid eyeglass prescription less than 1 year old? _____YES _____NO
Does your child have a vision problem or eye disease?
If so, describe: ________________________________
Does child complain of headaches? _____YES _____NO
Does your child squint? _____YES _____NO
Is your child on any medication that would affect their vision? _____YES _____NO
Has your child had an eye injury? _____YES _____NO
Does your child have diabetes? _____YES _____NO

Today's Vision Screening can help determine if your child sees as well as they should. Keep in mind, however, that many underlying factors may affect the results of the tests. Also, the screening does not test for all eye disorders.

Although this screening is a good indicator that your child is not seeing correctly or having problems, you should arrange for a professional eye examination, regardless of the result of the screening conducted here today. This screening has been funded by the Juvenile Welfare Board.

I give permission for my child to receive a vision screening.

X____

Parent or Guardian Signature **Date**

PVF STAFF USE ONLY: Time:__________

Date:

Screening Site:

____

Signed Written Statement of Purpose? _____

Color Blindness:

Pass: _____ Refer: _____ ________ initials

Distance Visual Acuity:

Right Eye: 20/_________Left Eye: 20/__________

Near Visual Acuity:

Right Eye: 20/_________Left Eye: 20/__________

Glasses worn? _________YES _________NO

Spot:

R: Sphere:_______ **L**: Sphere:_______

Cylinder:______ Cylinder:______

*If referral SE:_____ SE:_____

Pupillary Distance (PD) _______ mm

REFER:________ **for** ______________________

PASS: _________ _______ Screener initials

FOLLOW UP

- ☐ Sunglasses
- ☐ Referral Letter
- ☐ OO/Ophthalm list
- ☐ VPK package
- ☐ Spot Results
- ☐ Lenz Frenz Reminder
- ☐ Eye Condition Photo

Notes:

RELEASE OF INFORMATION and CONSENT FOR CARE FORM

Preserve Vision Florida

For release of confidential information between collaborating agencies

CHILD'S NAME:____

DOB:________________ SSN:______________________________

I understand that I will be receiving vision screening services through Preserve Vision Florida. I understand that the information obtained by Preserve Vision Florida will be shared for screening, assessing, planning, and facilitating the delivery of appropriate services by this program. With my written consent on this document, I understand that the agencies listed below may share records and information.

This consent authorizes release of information and discussion of ongoing services between all agencies listed below until time period as set forth below or I withdraw my consent:

- [X] Preserve Vision Florida (PVF)
- [X] Juvenile Welfare Board of Pinellas County (JWB)
- [X] Optometrist or Ophthalmologist to whom I am referred by Preserve Vision
- [ ] Pinellas County Public Schools
- [ ] FDLRS Child Find
  School:____
- [ ] Other Provider____
- [ ] Other Provider____

The purpose of this consent is: <u>Continuity of Care for vision services</u>.

I have given my consent freely and voluntarily. Preserve Vision will only disclose this information in accordance with law or as authorized by me.

This consent will expire upon satisfaction of the need for disclosure, not to exceed one year after the date signed, except for the purpose of payment, research, compliance, and quality assurance reviews. I may revoke this authorization at any time, providing I notify Preserve Vision Florida in writing to that effect. However, such a revocation will have no effect on any action previously taken and that it will not apply to any information already released to and/or used by any entity set forth above.

____
(print child's name)

____ ________________
Signature of Participant / Parent / Guardian (Please circle one) *Date*

____ ________________
Signature of Witness *Date*

Juvenile Welfare Board of Pinellas County
14155 58th Street North, Suite 100
Clearwater, FL 33760
Phone: 727-453-5600
Fax: 727-453-5610
www.jwbpinellas.org

Written Statement of Purpose(s) for Collection of Social Security Number for Recipients of JWB-funded Programs and Services

The Juvenile Welfare Board (JWB) invests in partnerships, innovation and advocacy to strengthen Pinellas County children and families. The vision of the JWB is that children in Pinellas County will have a future of more successful and satisfying lives because of the efforts of JWB and its partners. JWB was established by Florida statute in 1945 (Special Act 2003-320: F.S. §189.429) and approved overwhelmingly by voters in a referendum in 1946. JWB was created with a mission to provide needed services to children and families throughout Pinellas County. JWB funds services for children and families in Pinellas County.

The purpose of this document is to provide individuals with written information about how JWB uses the Social Security numbers it collects. JWB is required by Florida's Public Records law [Fla. Stat. §119.071(5)] to provide this information to you.

Florida law allows JWB to collect Social Security numbers in order to carry out its duties and responsibilities prescribed by law (Fla. Stat. §119.071(5) (a) 2a. (II); Special Act 2003-320: F.S. §189.429). Specifically, it is imperative for JWB to collect Social Security numbers to conduct research, fund services, and to ensure that all services delivered to participants are of the highest possible quality.

In addition, collecting Social Security information is necessary to:

• Identify and match individuals and data to research in order to improve services for children and families;
• Coordination of services: and
• Receive reimbursement from Medicaid, if applicable, for providing services.

Social Security numbers held by JWB are confidential and exempt from disclosure except as specifically authorized by law (Fla. Stat. §119.071) (5) (a) 5.). JWB follows the highest security standards. All reports produced by JWB provide information about services in general. No individual person is ever identified in any way in any report without JWB first obtaining that person's written consent.

______________________________	______________________________
Print Participant Name	Participant Signature / Date
______________________________	______________________________
Print Parent/Guardian Name (If participant is under 18 years of age)	Parent/Guardian Signature / Date (If participant is under 18 years of age)
______________________________	______________________________
Print Participant Name	Participant Signature / Date
______________________________	______________________________
Print Parent/Guardian Name (If participant is under 18 years of age)	Parent/Guardian Signature / Date (If participant is under 18 years of age)

Acknowledgment of Risks and Waiver of Liability Relating to Coronavirus/COVID-19

I acknowledge that on or about March 11, 2020, Coronavirus Disease 2019 ("COVID-19") was declared a pandemic by the World Health Organization. The Centers for Disease Control and Prevention ("CDC") has stated that **"the best way to prevent illness is to avoid being exposed to this virus."** https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html **.**

I am aware of the contagious nature of COVID-19 and have voluntarily chosen to allow my child(ren) to participate in the programs provided by Preserve Vision Florida ("PVF").

I acknowledge that PVF employees come in contact with multiple individuals, and might become exposed to COVID-19. I also acknowledge that although PVF takes precautions to reduce the likelihood of transmission of COVID-19 by its employees, PVF cannot guarantee that my child(ren) will not become infected with COVID-19.

I knowingly acknowledge that by allowing my child(ren) to participate in PVF's programs. I am exposing my child(ren) and myself to the risk of becoming infected with COVID-19, which may result in serious personal injury, illness, permanent disability, and death. I understand the risk of becoming exposed to or infected by COVID-19 may result from actions, negligence, and failures to act of myself and others, including, but not limited to, PVF employees, and other program participants and parents.

I agree to assume all of the foregoing risks, and accept personal responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability or expense, of any kind of nature, that I may suffer arising out of or in connection with my child(ren) or myself becoming exposed to or infected by COVID-19 while my child(ren) is/are participating in any PVF program. On my own behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, and forever discharge PVF, its employees, agents, and representative, of and from all liabilities, claims, actions, damages, costs or expenses of any nature ("Claims") arising out of or in any way connected with my child(ren) or myself becoming exposed to or infected by COVID-19. I understand that this release includes any Claims based on the negligence, action, or inaction of any of PVF, its employees, agents, and representatives, and covers bodily injury (including death) due to COVID-19, whether a COVID-19 infection occurs before, during or after participation in any PVF program.

____ ____

Parent or Guardian's Signature Parent or Guardian's Name Printed

____ ____

Date

____

____

Child(ren)'s Name (first and last)