Vision Screenings

2020-2021

Pinellas Park High School Clinic

Call for appt. 727-538-7410 x 2026

Tuesday, October 6, 2020

Tuesday, November 3, 2020

Tuesday, December 1, 2020

Tuesday, January 5, 2021

Tuesday, February 2, 2021

Tuesday, March 2, 2021

Tuesday, April 6, 2021

Tuesday, May 4, 2021

PRESERVE VISION
FLORIDA

Children's Vision Screening

Preserve Vision Florida will be conducting FREE vision screenings at our school for the children.

Please fill this registration packet out completely, sign and return to the director if you would like your child to participate in this important screening.

If your child doesn't pass the screening, and you do not have insurance that covers vision, PVF may be able to help with the follow-up exam and glasses with an optometrist.

This program is funded by the Juvenile Welfare Board of Pinellas County.

Why do children need vision screenings?

Young children with vision problems often do not see the world as they should. Vision problems affect 1 in 20 preschoolers and 1 in 4 school children. Without early detection and treatment, a child's vision problem can lead to learning difficulties or permanent vision loss.

Only an eye doctor can diagnose and treat a vision problem, but screenings help identify children who need a full eye exam.

What is Preserve Vision Florida's Children's Vision Screening Program?

Preserve Vision Florida's vision screeners are trained and certified through the only national program that trains and certifies people around the country to conduct screenings that find vision problems in preschool and school-age children. Our screening procedures are recommended by many of the nation's leading children's eye care professionals and researchers.

What happens at a Preserve Vision Florida's Children's Vision Screening?

Observation - The screener checks the child's eyes for signs of problems such as watering or swollen/crusted lids. Screeners watch the child's behavior, rubbing the eyes or tilting the head may be an indication that the child has difficulty seeing.

Spot Vision Screener testing - The Spot Vision Screener is a photorefractor that does not require dilation and requires minimal cooperation from the child while screening both eyes at once from a nonthreatening 3-foot distance. The device takes a series of photos of the eyes and maps the eyes for near- and far-sightedness, astigmatism, unequal power between eyes, eye misalignment and unequal pupil size. A child that has difficulty seeing things at a distance may have trouble seeing the blackboard at school or performing well at sports. Typically this can be corrected with a pair of prescription glasses. Children whose eyes do not work together are at risk for lazy eye (amblyopia). Lazy eye can cause lifelong vision loss in the affected eye, but if caught early can be successfully treated.

Color blindness testing - Color blindness is a deficiency in the way you see color. With this vision problem, a child will have difficulty distinguishing certain colors, such as blue and yellow or red and green. Color blindness (or, more accurately, color vision deficiency) is an inherited condition that affects males more frequently than females. An estimated 8 percent of males and less than 1 percent of females have color vision problems. This can be very frustrating for the person-especially as it relates to learning, eventually driving, and navigating the world.

Statement on Screening

Preserve Vision Florida's children's vision screening can help determine if your child is seeing as well as they should. Please note that many underlying factors may affect the results of the screening and does not check for all eye disorders.

Although this screening is a good beginning to checking your child's vision, it is not a substitute for a professional examination by an eye doctor. If you suspect that your child is not seeing correctly or is having vision problems, you should arrange for a professional eye examination, regardless of the results of the screening conducted today.

If you have any questions concerning our vision screening program please contact:

Jennifer Whittington
Vice President-Program
Preserve Vision Florida
(813) 874-2020 ext. 4025
jwhittington@pvfla.org www.pvfla.org

Please know that it is our expectation that you are completely satisfied with our services & staff. If you have any feedback please access our "Client Satisfaction" survey at: www.pvfla.org under "contact" or our incident report at: https://www.pvfla.org/wp-content/uploads/2018/04/PVFIncident-Report-2018.pdf Thanks!

PRESERVE VISION
FLORIDA

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

jwb Juvenile Welfare Board

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

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
FLORIDA

Preserve Vision Screening Registration
(continued)

jwb 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:

_____

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

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

Notes:

RELEASE OF INFORMATION and CONSENT FOR CARE FORM

Preserve Vision Florida

For release of confidential information between collaborating agencies

PRESERVE VISION FLORIDA

CHILD'S NAME: _____

DOB: _____

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
- [X] School: _____
- [ ] Other Provider _____
- [ ] Other Provider _____

The purpose of this consent is: Continuity of Care for vision services.

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*

PRESERVE VISION
FLORIDA

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)