Prevention of Blindness Society
of Metropolitan Washington®

Free Eye Exam and Glasses

Dear Parent/Guardian,

Your child's school has partnered with the Prevention of Blindness Society of Metropolitan Washington (POB) to evaluate your child's vision and provide a free eye exam and eyeglasses (if needed) **AT NO CHARGE TO YOU**. **Complete this form and SIGN AT THE BOTTOM so your child can receive services.**

➢ Student First and Last Name:_____

➢ Student Date of Birth (MM/DD/YYYY):_____/_____/_____

➢ Student Home Zip Code:_____

➢ Student Medicaid ID (if available):_____

➢ Parent/Guardian Name:_____

➢ Parent/Guardian Cell Phone:_____

I give my permission for my child to have vision screening. If the vision screening is failed, I give permission for either 1) a complete eye exam soon after/or on the day of eye screening by an ophthalmologist or optometrist and/or 2) a referral to an ophthalmologist or optometrist for more examination/care. (Complete eye exams include using eye drops that enlarge the pupils for a short time so that the inside of the back of the eye can be examined. The drops make the vision blurry and sensitive to light for a few hours. They do not harm the eyes.) If the eye exam indicates that eyeglasses and no immediate follow-up is needed, the glasses will be ordered with a licensed optician shortly after the screening.

I hereby agree to indemnify and hold harmless and blameless the Prevention of Blindness Society of Metropolitan Washington ("POB"), Children's National Health System, and their officers, employees, volunteers or agents from any and all liability from damages, loss, or injuries, either to person or property, which the above-named minor may sustain while participating in, or otherwise arising from or related to the vision screening program. I further certify that I have legal custody of the named minor by reason of the fact that I am the minor's parent or legal guardian by court order.

I give permission for my child to have his/her photo, name, image or likeness used for all editorial, promotion, advertising, trade, or otherwise on behalf of POB, and in any and all media now known or hereafter devised, including, but not limited to, print, TV, electronic, or World Wide Web, without further limitation, restriction, compensation, notice, review or approval. By signing this agreement, I am releasing POB of any legal requirements and fully understand that I am leaving my discretion of release materials up to the administration of POB.

Receiving vision services provided by POB will constitute a routine vision examination and – as needed – fitting of glasses and eyeglasses that may be billed to your child's Medicaid benefits, if applicable. POB is eligible to receive Medicaid reimbursement for certain health-related services provided to your child when the services meet Medicaid requirements.

By signing below, I voluntarily give POB my consent to share my child's name, zip code, date of birth, Medicaid number, and the date of the services provided with Medicaid representatives. I also authorize the release of this information to Medicaid representatives for the purpose(s) of determining eligibility and/or completing audit requests. I understand and agree that POB may access my child's Medicaid benefits to pay for these services.

A FREE eye exam and eyeglasses will be provided to your student, even if your student does not have Medicaid and/or if Medicaid cannot be billed.

➢ **CONSENT FOR MEDICAID REIMBURSEMENT (please check the appropriate box below)**

- ❒ I am providing consent to bill for Medicaid reimbursable services
- ❒ I decline to provide consent to bill for Medicaid reimbursable services

IF YOUR CHILD WEARS EYEGLASSES, PLEASE HAVE YOUR CHILD BRING THEM ON THE EXAM DAY.

➢ Parent/Guardian Signature_____ Date_____