

VISION



San Francisco Unified School District
Student Support Services Department
1515 Quintara St.
San Francisco, CA 94116
415/242.2615
Fax: 242.2618
[Http://www.healthiersf.org](http://www.healthiersf.org)

FROM: Vision Screening Program
DATE: 2011-2012 School Year
SUBJECT: **Your school is scheduled for Vision Screening on _____.**

Packet Contents (to be mailed to school site prior to screening)

- Letter of instruction from Optometrist
- MCT vision screening information
- Scantron listings of students in grades 1 & 4
- Student ID and mailing labels
- Teacher referral forms
- Referral letters
- "Vision Screening Summary"
- Color vision letter

INSTRUCTIONS

Prior to Vision Screening Date

1. **Please check that your scantrons are complete (students in grades 1 & 4).**
If scantrons are incomplete, please call Information Technologies at 241-6173.
2. **Reproduce teacher referral form and distribute to all teachers in grades K, 2, 3, 5, 6, 7, 8). All student information requested on teacher referral forms must be complete prior to screening.**
3. Please review letter of instruction.
4. Please place the following paperwork in vision packet & provide safekeeping for Vision Screeners: (a) all scantrons and labels, (b) completed teacher referral forms, (c) school bell schedule and classroom roster with intercom numbers, (d) referral letters, and (e) vision screening summary.

On Day of Vision Screening

1. Implement instructions as documented on optometrist letter.
2. Give entire vision packet with contents to Vision Screeners when they arrive on site.
3. **During screening, students are to be supervised by school teachers/site staff for safety and discipline. Please do not leave students unsupervised with Screeners.**
4. Once screening is complete, students may return to class.

After Vision Screening is Complete

1. **Following vision screening, the screeners will return the vision packet to you, complete with screening results. PLEASE PROVIDE SAFEKEEPING FOR THIS PACKET.** A SSSD School Health Worker will contact you to make arrangements to pick up the packet and record screening results. Please make cum folders, envelopes, and work space available to Health Worker.
2. Health Worker will provide a list of student referrals with instructions for the Site Administrator/Site Coordinator after recording is complete.
3. Completed referrals from the Eye Care Providers will be forwarded to Site Administrator from SSSD. These completed reports are to be shared with classroom teachers and filed in the students' cum folders for future reference.
4. SSSD may request assistance from Site Administrator/teachers for those referred students who did not receive follow-up.

We appreciate your time and assistance in the organization of this screening. If you have any questions or concerns, please do not hesitate to call the Nurse of the Day at 242-2615.

VISION SCREENING



August 2011

Dear Principal:

Vision Screeners are coming to your school on _____.
Doctors of Optometry will screen children in grades 1 and 4 and referrals from other elementary and middle school grade levels using the MCT (Modified Clinical Technique) method. Student being referred for SSTs, educational testing or triennial reviews should be screened at this time. In addition, teacher referrals (from all other elementary grade levels) and students new to the school system should also be screened.

Please provide the optometrists with the following:

1. A quiet, fairly dark room, 20' by 20' minimum, with an electrical outlet and telephone.
2. **An assistant** (a parent volunteer, or a 5th or 6th grader, for instance)
3. A table with two sturdy chairs per doctor.
4. Movie/Projector screen.
5. A bell schedule and a phone list.

Teachers need to:

1. Bring the students to the screening in alphabetical order by last names.
2. Put the names and HÓ numbers of any *additional* (referral) students to be tested on the appropriate referral forms.
3. Advise the children, on the day prior to the screening, to bring their eyeglasses to school for the screening the following day.

We look forward to meeting and working with you and your staff and students. Should you have any questions, please call Student Support Services Department and ask for the Nurse of the Day at 242-2615.

VISION SCREENING



MCT VISION SCREENING PROCEDURES:

1. Visual acuities of each eye are taken using a Snellen letter chart, number chart, tumbling E's or object recognition near chart.
2. Retinoscopy is done to determine whether or not there is significant refractive error.
3. Cover test is used to detect and measure any extraocular muscle imbalance at distance or near which is outside of screening guidelines.
4. Observation of eye health and vision habits are noted.
5. Ophthalmoscopy is done when there are clues that further observation is warranted.
6. History from the child and/or teacher is taken if a child seems to be a borderline referral.
7. Color test is used to screen all second grade boys.

RESULTS AND REFERRAL CRITERIA:

P = pass All screening criteria have been passed.

R = referral Child's vision or eyes have not passes the screening.

A = absent Child did not have a vision screening.

REFRACTIVE ERRORS:

- **Myopia or nearsightedness.** The inability to see clearly at distances but may see clearly at near. May need glasses to see far away.
- **Hyperopia or farsightedness.** With this condition, the eyes must focus to see distance clearly and must focus even more in order to see clearly for reading. Most kindergarten and second-graders are farsighted.
- **Astigmatism.** Refractive error which is greater in one meridian than another. A person with astigmatism may have blurry vision. They might see clear horizontal lines and blurred vertical lines so that a word would look "smeared" as if by a chalkboard eraser. Vision would be blurred both at distance and at near and might cause headaches
- **Amblyopia ("lazy eye"):** One eye has poor vision, even with prescription lenses.

- **Anisometropia or an unequal refractive error:** The two eyes may have unequal amounts of farsightedness, nearsightedness or astigmatism. In this case, the two eyes cannot focus at the same point together.
- **Extraocular muscles (EOM):** There is a significant tendency for the eyes to deviate or point outward, inward, upward, or downward.
- **Color vision:** This section is marked if a child is red-green color anomalous. It is only to inform the parent and teacher. There is no treatment to correct color vision anomalies. If the parent has any questions, an eye doctor should be contacted. Otherwise no further evaluation is required.
- **VIP=visually impaired:** Indicates a child with significant visual difficulty, blindness, or low vision.

**Please return this form to the school secretary by _____

VISION SCREENING 2011-2012

TEACHER REFERRAL FORM

School _____ Screening Date _____ / _____ / _____

Poor vision in children can interfere with acquisition of skills and the ability to learn properly. Vision screening is a state requirement (C.E.C. 49455). **Effective Fall 2011, vision and hearing screening will be conducted for grades 1 & 4.** Teacher referrals from other grade levels can also be screened at this time. Please enter in the space provided below, students from grades K, 2, 3, 5, 6, 7 or 8 whom you wish to refer for screening. Students must meet a minimum of one of the following criteria in order to be referred:

- Students who appear to have visual problems (i.e.: complaints of headaches, squinting, complaints of blurred vision with or without glasses), and students with poor academic performance for unknown reasons.
- Students who have or may be referred for a SST or educational testing. State law requires that any student receiving educational testing must have both vision and hearing screening within one year prior to testing.
- Special Education students who have an upcoming Triennial Review.
- Students new to the district

I am referring the following students for vision screening (screening requires all information to be complete).

LEGAL NAME ON FILE Last Name	First Name	Gr	HO #	REASON/SYPTOMS	Glasses Y/N	SCREENING RESULTS (Completed by Screeners Only)									
						R20/ L20/	M M	H H	AS AS	AN EOM	P P	F F	A A	R R	W W
						R20/ L20/	M M	H H	AS AS	AN EOM	P P	F F	A A	R R	W W
						R20/ L20/	M M	H H	AS AS	AN EOM	P P	F F	A A	R R	W W
						R20/ L20/	M M	H H	AS AS	AN EOM	P P	F F	A A	R R	W W
						R20/ L20/	M M	H H	AS AS	AN EOM	P P	F F	A A	R R	W W
						R20/ L20/	M M	H H	AS AS	AN EOM	P P	F F	A A	R R	W W
						R20/ L20/	M M	H H	AS AS	AN EOM	P P	F F	A A	R R	W W
						R20/ L20/	M M	H H	AS AS	AN EOM	P P	F F	A A	R R	W W

Name of Teacher _____ Grade _____ Room _____

LEGAL NAME ON FILE Last Name	First Name	Gr	HO #	REASON/SYMP TOMS	Glasses Y/N	SCREENING RESULTS (Completed by Screeners Only)							
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W
						R20/ L20/	M H	H AS	AS AN	EOM	P F	A R	W

SCREENING RESULTS:

RX: Prescription. Wearing glasses during exam.
EOM: Extraocular Muscles: Eyes tend to deviate from straight position
M: Myopia or Nearsightedness. May not see clearly at distances
H: Hyperopia or Farsightedness. The eyes must focus to see distance clearly and must focus even more in order to see clearly for reading.
AS: Astigmatism. May result in blurred near and distance vision. May result in headaches.
AN Anisometropia: Unequal refractive error

P: Pass
F: Fail/Refer
A: Absent
R: Recheck Next Year
W: Color Vision Referral



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 Http://www.healthiersf.org

Dear Parent/Guardian:

Part of the mission of Student Support Services Department is to improve the health and well being of all students within the San Francisco Unified School District. In an effort to ensure the visual health of your child, a nurse conducted vision screening at your child's school on _____. The results of your child's vision screening indicated that further examination is recommended.

- If an Eye Doctor has already examined your child within the last 12 months, please sign this form and mail it to the above address. No further follow-up is needed at this time.

_____ / ____ / ____
 Signature of Parent/Guardian Date

- If an Eye Doctor has not examined your child within the past year, please take your child to an eye doctor for further evaluation or treatment. Please have your doctor complete the back of this form and mail it to the address above.

If you do not have an Eye Doctor, you may contact your own medical practitioner for a referral or go to an eye doctor near your home. Please assure that the eye doctor accepts your insurance prior to making an appointment. If you do not have eye insurance, please review the attachments with this referral.

If you have questions regarding this referral, please do not hesitate to contact the Nurse of the Day at (415) 242-2615. Thank you.

VISION SCREENING RESULTS

_____	_____	_____	_____
<i>Legal Name of Student</i>	<i>School</i>	<i>Gr</i>	<i>HO#</i>
_____	_____		
<i>Street Address</i>	<i>City/Zip Code</i>		

SNELLEN TEST: (R) 20/_____ (L) 20/_____ <input type="checkbox"/> Examined with glasses on			
<input type="checkbox"/> Myopia	<input type="checkbox"/> Hyperopia	<input type="checkbox"/> Astigmatism	<input type="checkbox"/> ___ tropia
Other: _____			

Dear Eye Care Practitioner:

This student is being referred to you because s/he did not pass vision screening at school. Please examine the child, complete the report below and return it to:

Student Support Services Department
Attention: Vision Screening Program
1515 Quintara Ave., San Francisco, CA 94116

DATE OF EXAM: ____/____/____

VISUAL ACUITY	WITHOUT CORRECTIVE LENSES	WITH CORRECTIVE LENSES	NEAR ACUITY	<input type="checkbox"/> WITH RX	<input type="checkbox"/> WITHOUT RX
O.D.					
O.S.					
O.U.					

Refractive Condition: _____

Binocular Vision Assessment: WNL Other _____

Ocular Health: WNL Other _____

Were Glasses Prescribed? Yes No

Child Should Wear Glasses

- All the time
- Classroom Only
- Other (Please Explain)

Recommended School Services:

- Regular Class
- Preferential Seating
- Referral for Special Education Services for Visually Impaired
(If this option is selected, form SE-03 State Dept. of Ed., will be sent to you for completion.)
- Other (Please Explain)

Doctor Signature _____

Address _____ Telephone _____

Dear Eye Care Practitioner:

This student is being referred to you because s/he did not pass vision screening at school. Please examine the child, complete the report below and return it to:

Student Support Services Department
Attention: Vision Screening Program
1515 Quintara Ave., San Francisco, CA 94116

DATE OF EXAM: ____/____/____

VISUAL ACUITY	WITHOUT CORRECTIVE LENSES	WITH CORRECTIVE LENSES	NEAR ACUITY	<input type="checkbox"/> WITH RX	<input type="checkbox"/> WITHOUT RX
O.D.					
O.S.					
O.U.					

Refractive Condition: _____

Binocular Vision Assessment: WNL Other _____

Ocular Health: WNL Other _____

Were Glasses Prescribed? Yes No

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Recommended School Services:

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(If this option is selected, form SE-03 State Dept. of Ed., will be sent to you for completion.)
- Other (Please Explain)

Doctor Signature _____

Address _____ Telephone _____



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親愛的家長/監護人:

改善三藩市聯合校區所有學生的健康是學生支援服務部任務的一部份。為這緣故，並且遵照加州法律規定，已於_____在您的學校進行視力檢查。結果顯示，您子女需接受進一步檢查。

- 過去12個月內，若您子女已接受視力檢查，請填妥本表格，並將之寄回上址。

_____ / ____ / ____
 家長/監護人簽名 日期

- 過去一年內，若您子女沒有接受眼醫的視力檢查，那麼就請帶子女去看眼醫，接受進一步檢查，並請醫生填妥本表格背面的轉介表格，寄回上址。

若您沒有自己的眼醫，可請醫護人員轉介，或聯絡就近自己住所的眼醫。預約前，需確實該眼醫接受您的保險。若沒有眼科保險，請參閱附件。

如有問題，請聯絡當值護士，電話: (415) 242-2615。謝謝。

視力檢查結果

_____	_____	_____	_____
學生法定姓名	學校	年級	學號 HO#
_____	_____		
地址	城市/ 郵區編號		

斯內倫視力測驗： (右眼) 20/ _____ (左眼) 20/ _____				<input type="checkbox"/> 檢查時戴眼鏡
<input type="checkbox"/> 近視	<input type="checkbox"/> 遠視	<input type="checkbox"/> 散光	<input type="checkbox"/> 斜視	
其他: _____				

Dear Eye Care Practitioner:

This student is being referred to you because s/he did not pass vision screening at school. Please examine the child, complete the report below and return it to:

Student Support Services Department
Attention: Vision Screening Program
1515 Quintara Ave., San Francisco, CA 94116

DATE OF EXAM: ____ / ____ / ____

VISUAL ACUITY	WITHOUT CORRECTIVE LENSES	WITH CORRECTIVE LENSES	NEAR ACUITY <input type="checkbox"/> WITH RX <input type="checkbox"/> WITHOUT RX
O.D.			
O.S.			
O.U.			

Refractive Condition: _____

Binocular Vision Assessment: WNL Other _____

Ocular Health: WNL Other _____

Were Glasses Prescribed? Yes No

Child Should Wear Glasses

- All the time
- Classroom Only
- Other (Please Explain)

Recommended School Services:

- Regular Class
- Preferential Seating
- Referral for Special Education Services for Visually Impaired
(If this option is selected, form SE-03 State Dept. of Ed., will be sent to you for completion.)
- Other (Please Explain)

Doctor Signature _____

Address _____ Telephone _____



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415/242.2615
Fax: 242.2618
[Http://www.healthiersf.org](http://www.healthiersf.org)

VISION SCREENING RESULTS – Color Vision

<hr/> <i>Name of Student</i>	<hr/> <i>School</i>	<hr/> <i>Gr</i>	<hr/> <i>HO#</i>
<hr/> <i>Address</i>	<hr/> <i>City/Zip Code</i>		

Dear Parent/Guardian:

Part of the mission of Student Support Services Department is to improve the health and well being of all students within the San Francisco Unified School District. It is important to remember that healthy children learn more effectively.

In an effort to ensure the visual health of your child, a vision screening test was done at your child's school on _____. At that time, your child was tested for red-green color vision. During this test, your child was not able to see all the different shades of color. This may result in confusion when s/he tries to match colors.

There is no medical treatment indicated for color vision defects. No further evaluation of your child is required. However, if you have further questions or concerns, please contact your eye care practitioner or the Vision Screening Program, Student Support Services Department at 242-2615.

Thank you for your attention.



SAN FRANCISCO PUBLIC SCHOOLS

RESULTADOS DEL EXAMEN DE LA VISTA – color vision

Nombre del estudiante Grado Aula
Dirección de la Escuela / /
Ciudad/Zona postal Fecha de nacimiento

Estimado padre/madre ó guardian legal:

Parte de la misión del Departamento para Servicios de Apoyo a Estudiante es, la de mejorar la salud y bienestar de todos los estudiantes del Distrito Escolar Unificado de San Francisco. Es importante recordar que los estudiantes saludables aprenden con más eficacia.

En un esfuerzo por mejorar la salud visual de su hijo/a, se le hizo un examen de la vista en su escuela el día . En esta ocasión se le examinó para saber si podía distinguir los colores color rojo y verde. Durante este examen, se detectó que no era capaz de distinguir el tono de esos colores, y ésto puede ocasionarle confusión cuando trate de distinguirlos.

No existe un tratamiento médico para los defectos que ocasiona la falta de discriminación de los colores. No se requieren más evaluaciones. Si tienen alguna pregunta o inquietud, por favor, comuníquense con su oculista o con el Programa encargado del Examen de la Vista, del Departamento de los Programas para la Salud Escolar al teléfono 242-2615.

Gracias por su atención

Vision/VisionPacket/Referralsletters0910

San Francisco Unified School District
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Fax: 242.2618
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視力測驗結果 – color vision

學生姓名 年級 室號
地址 學校
城市/郵區編號 / / 出生日期

親愛的家長/監護人：

學校健康計劃部的宗旨是促進三藩市聯合校區全體學生的健康，為全體學生謀福利，因為學生有健康的身體，學習才更有效果。

為確保您子女有健康的視力，本部已安排於在您的學校進行視力測驗，測驗您子女的紅色彩視覺。結果顯示，您子女不能分辨不同的色澤。因此，當您子女要選擇匹配的顏色時，會感到混淆。

您子女色彩視覺方面雖有毛病，但結果沒有顯示您子女需要接受治療，因此您子女不需進一步的評估。如有進一步問題，請聯絡自己的眼科醫生或學校健康計劃部視力測驗計劃組，電話：242-2615。

您對這事的關注，謹此致謝。
學校健康計劃部 啓



SFUSD SAN FRANCISCO
PUBLIC SCHOOLS

San Francisco Unified School District
Student Support Services Department
1515 Quintara St.
San Francisco, CA 94116
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Fax: 242.2618
Http://www.healthiersf.org

VISION SCREENING SUMMARY

SCHOOL	_____
DATE SCREENED	_____
TOTAL NUMBER SCREENED	_____
TOTAL NUMBER ABSENT	_____
TOTAL COLOR ANOMALIES	_____
TOTAL NUMBER REFERRED	_____

SIGNATURES: SCREENERS

SIGNATURES: RECORDERS

(Please Note Recording Date)



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____ / ____ / ____

Dear Site Administrator:

Subject: Vision Screening Results

We appreciate your assistance and flexibility with the screening recently conducted at your school site. Our goal is not only testing the students but completion of the follow-up which results in increased student success.

Attachments:

- Student Referral List: Students listed here did not pass the screening noted above and are being referred for further evaluation.
- Referrals: **All referrals are to be sent by the school to students' home via normal school communication mechanism (i.e.: mail, weekly envelopes, backpack etc).** Initial referrals are attached here. Second notices with instructions will be mailed to your school site from Student Support Services Department 6-8 weeks after this screening. All completed referrals should be returned to Student Support Services Department (SSSD) at 1515 Quintara Street.
- Staff Letter
- Resources for Follow-up: Resources are already included on the referral to families. The list attached here is for schools use.

We request that until these students receive further evaluation, please at your discretion use preferential seating where necessary. We would appreciate your assistance in encouraging the parent/guardian to seek medical follow-up. For further information, please contact the Health Worker assigned to your site or Student Support Services Department at **242-2615**. Thank you for your assistance.

Sincerely,

Mandated Screenings Program
Student Support Services Department



San Francisco Unified School District
Student Support Services Department
1515 Quintara Street
San Francisco, CA 94116-1273
Tel 415.242.2615
Fax 415.242.2618
www.healthiersf.org

____ / ____ / ____

Dear Site Administrator:

Subject: Vision Screening Results, Second Notices

We appreciate your assistance with the screening and follow-up at your school site. Our goal at this stage is for completion of the follow-up which results in increased student academic success.

- Referrals (Second Notices): We have included second notices here for those students whom we did not receive any response to the first referral. Referrals are to be sent by the school to students' home via normal school communication mechanism (i.e.: mail, weekly envelopes, backpack etc). All completed referrals should be returned to Student Support Services Department (SSSD) at 1515 Quintara Street.
- Staff Letter
- Resources for Follow-up: Resources are already included on the referral to families. The list here is for schools use.

We request that until these students receive further evaluation, please at your discretion use preferential seating where necessary. We would appreciate your assistance in encouraging the parent/guardian to seek medical follow-up. For further information, please contact the Health Worker assigned to your site or Student Support Services Department, 242-2615. Thank you for your assistance.

Sincerely,

Mandated Screenings Program
Student Support Services Department



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Student Support Services Department
1515 Quintara St.
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[Http://www.healthiersf.org](http://www.healthiersf.org)

Date: ____/____/____



Teachers, Administrators & Other Staff

The students listed on the following page failed the vision screening that was done on ____/____/____.

What is a Vision Screening?

One out of four students between the age 5 and 12 has a vision problem which may adversely effect the child's academic performance, health and well being. A school vision screening is one tool to assist in detecting vision problems. School screenings are done by optometrists and are an excellent means for a quick overview of the eye. They do not however, replace a comprehensive eye exam by an eye specialist. Even if a student passes a school vision, if the child is having difficulty with vision in the classroom, a professional eye examination is warranted.

What does a failed vision screening indicate?

A failed vision screening indicates a need for further assessment by an eye specialist. A failed screening is not a confirmed diagnosis of an eye or vision problem.

What's being done to ensure follow-up?

1. Referrals are being prepared by your Health Worker and will be given to your school site for mailing to students' parents/guardians.
2. In 4-6 weeks, second notice referrals will be prepared for those students who did not respond to the first referral. These referrals will be given to your site for mailing.

What can teachers, administrators, and other staff do?

- We request that until these students receive further evaluation, please at your discretion use preferential seating where necessary.
- When speaking to parent/caregiver, please mention the importance of medical follow-up. Resources for free and low cost eye care are included in the referral. We have included these resources here for your reference.

Thank you!



King thua quy vi Phu Huynh/GiamHo:

Con em quy vi Vua Duoc thu nghiem tam nhin cua mat tai trung vao ngay _____. Ket qua cho biet co the co vn de vet hi giac.

Neu con em quy vi co deo kieng va/hoac da duoc bac si nhan khoa kham nghiem trong vong 12 tang vua qua, xin vui long dien ten con em va ky mau don nay va goi den dia chi phia tren.

Ten hoc sing _____ / _____
Truong hoc _____ Chu ky Phu Huynh/Giam Ho

Xin vui long dua con em quy vi den bac si nhan khoa de duoc kham hoac dieu tri ky cang hon neu con em quy vi chua duoc bac si nhan khoa kham trong vong mot nam qua. Neu quy vi khong co bac si hay benh vien nhan khoa, quy vi co the lien lac voi mot trong nhung dia diem duoi day:

*San Francisco General Hospital Eye Clinic 1-415-206-3228

Mahal na Magulang/Tagapagalaga:

Bahagi sa layunin ng Student Support Services Department ay mapagbuti ang kalusugan at kapakanan ng mga mag-aaral sa SFUSD. Importanteng malaman na ang mag-aaral na malusog ay madaling matuto.

Sa aming pagsisikap na makatiyak na malusog ang mata o paningin ng inyong anak, siya ay nagkaroon ng test o pagsusuri sa mata sa paaralan noong _____.
Ang test o screening sa mata ay ginagawa upang masuri kung may posibleng suliranin sa mata o paningin. Ayon sa resulta sa pagsusuri sa inyong anak, siya ay kailangang madala sa doctor sa mata para sa maingat at karagdagang pagsusuri.

Kung ang inyong anak ay natignan na o nasuri sa sa loob ng 12 buwan paki-firma lang ang liham na ito at ipadala sa koreo sa nasabing direksyon sa itaas.

Pangalan Ng Estudyante _____ / _____ Paaralan Ng Estudyante

Lagda Ng Magulang/tagapagalaga _____ Petsa

Kung ang inyong anak ay hindi pa nasuri o na-eksamin ng doctor sa mata sa nakaraang taon, pakidala ang inyong anak sa doctor sa mata para sa maingat at karagdagang pagsusuri. Ipasagot at ipakumpleto sa doktor ang nasa likod ng liham o pormang ito at ipadala sa koreo sa nasabing direksyon sa itaas. Kung wala kayong doktor sa mata puwede kayong tumawag sa mga sumusunod:

*San Francisco General Hospital Eye Clinic 1-415-206-3228

Kung kayo ay may katanungan, huwag mag-atubiling tumawag sa Vision Screening Program sa teleponong 415-2422615.
SALAMAT PO.

學生姓名 _____

學校 _____

親愛的家長/監護人:

學校健康計劃部的其中一個宗旨是改善三藩市聯合校區所有學生的健康。為確保您子女的視力健康，校區的驗光師已於 _____ 在您子女的學校進行視力檢查。您子女的視力檢查結果顯示，您子女需接受進一步檢查。

若過去 12 個月內，您子女已接受眼醫的檢查，請填妥本表格，並寄回上址。

家長/監護人簽名 _____

日期 _____ / _____ / _____

若過去 12 個月內，您子女沒有接受眼醫的檢查，請帶子女去看眼醫，接受進一步評估或治療，並請醫生填妥本表格背面的表，寄回上址。若您沒有自己的眼醫，可向以下地方查詢：

三藩市總醫院眼科診所 (San Francisco General Hospital Eye Clinic) ，
電話：1-415-206-3228。

如有問題，請聯絡學校健康計劃部，電話：415-242-2615。謝謝。

Nombre del estudiante _____

Escuela _____

Estimado padre de familia o encargado:

Parte de la misión del Departamento para Servicios de Apoyo a Estudiante es el mejoramiento de la salud y el bienestar de todos los estudiantes del Distrito Escolar Unificado de San Francisco (SFUSD). En un esfuerzo para garantizar la salud visual de su hijo/a, los optometristas del SFUSD condujeron un examen de la vista de su hijo/a en su escuela el _____ De acuerdo a los resultados se recomienda que se le haga otra evaluación.

Si el oculista ya examinó a su hijo/a en los últimos 12 meses, por favor, firme este formulario y envíelo por correo a la dirección de arriba.

Firma del padre de familia o encargado _____

Fecha _____ / _____ / _____

*Si el oculista no examinó a su hijo/a el año pasado, por favor, lleve al estudiante a la clínica del oculista para una evaluación o tratamiento. Por favor, dígame al médico que complete el formulario que se encuentra al reverso de esta hoja y que lo envíe por correo a la dirección de arriba. Si no cuenta con los servicios de un oculista, puede comunicarse con uno de los lugares siguientes:

*San Francisco General Hospital Eye Clinic 1-415-206-3228

Si tiene preguntas, por favor, no dude ni por un instante en llamar al 415-242-2615 del Departamento de Programas para la Salud Escolar. Muchas gracias.

VISION RESOURCES

Directive to Administrators (Specify which administrators)		WAD (Wednesday) Publication Date	WAD Notice Number	No. of Pages
All Site Administrators		January 26, 2011		1 of 16
WAD Title (Limit to 4-6 Words)			Date Due (if applicable)	Not Applicable After
Resources for Eye Exams and Glasses			N/A	May 27, 2010
From	Title	Signature		Telephone
Kim Coates (Cabinet member or approved by one below)	Supervisor, Student Support Services			242-2615
Inform <input type="checkbox"/> (x) Certificated Staff <input type="checkbox"/> (x) Classified Staff <input type="checkbox"/> (x) Parents <input type="checkbox"/> (x) Post on Bulletin Board Other <u>As Needed</u>				
Administrative Directive				
WHO: Students at SFUSD schools needing FREE resources for EYE EXAMS/GLASSES				
WHAT: Poor vision in school age children can interfere with coordination, acquisition of skills, achieving developmental milestones, and the ability to learn properly. Early detection and correction of vision problems can alleviate some of these problems with less interference in the child's ability to learn.				
WHERE: The following organizations provide free and/or low cost vision care and glasses for SFUSD students who qualify:				
<ul style="list-style-type: none"> • Children's Vision First • California Vision Project • LensCrafters 				
HOW: <u>Eligibility</u>				
1) Students have either failed the school based vision screening or have demonstrated a need for vision care. 2) Family has economic need and no health insurance that covers eye exams and/or glasses. <p style="text-align: center;">OR</p> 3) The family has economic need and has vision insurance but has lost/damaged their glasses and is unable to get new glasses under their current insurance plan.				
<u>To Apply</u> Instructions and applications attached. For questions, please contact:				
Nurse of the Day Student Support Services Department 242-2615				
Approved	Cabinet Member Kevin Truitt	Title Associate Superintendent, Student Support Services	Signature	
<i>SAN FRANCISCO UNIFIED SCHOOL DISTRICT - WEEKLY ADMINISTRATIVE DIRECTIVE (WAD)</i>				

Children's Vision First

(Formerly JVQ California)

1007 General Kennedy Ave. Suite 210

San Francisco, CA 94129

415.561.7793 phone

415.409.0587 fax

Principals

Students in your schools have an opportunity to participate in the new Children's Vision First vision program, which provides free eye exams and glasses for children who are in need and do not have health insurance.

The Children's Vision First program is designed to be simple and also flexible enough to empower the teachers and health care providers in your schools to identify children who are in need of help and are not being served through existing resources.

Children Who Are Eligible:

- Have failed school based vision screening (grades K: 20/40, grades 1-12: 20/30).
- Have no health insurance that covers eye exams and glasses.
- Have no economic resources to provide for adequate vision care. (These students are usually eligible for, or are already participating in, the Free or Reduced Lunch Program.)

Making Referrals:

- Referrals can be made by any school employee who can verify the child's eligibility. This is usually the nurse, health clerk or teacher.
- Since not all grades are screened, teachers are especially vital in referring children from those grades not being screened.
- Teachers must make sure that any child suspected of having vision problems is brought to the attention of the school nurse or vision screener for testing.
- Each child failing the vision screening must then be qualified for eligibility for the Children's Vision First program.
- Qualification includes confirmation that the child has no vision insurance and is without economic means for adequate vision care.
- After a child has been qualified, a Children's Vision First Referral Form is filled out and faxed to Children's Vision First.
- Children's Vision First will assign the student to a doctor in his or her neighborhood and mail the doctor's information to the child's parent/guardian. A copy of this letter is faxed to the school contact that referred the child.
- The parent must call their assigned doctor to schedule the appointment.
- The child then receives a free eye exam, and if glasses are required, CVF will manufacture free, quality new glasses and send them to the doctor for dispensing.

Better vision is one of the easiest things we can do to improve a child's potential. If you have any questions, please call Children's Vision First at 415.561.7793

Keeping CHILDREN in focus

Children's Vision First

(Formerly JVQ California)

1007 General Kennedy Ave. Suite 210

San Francisco, CA 94129

415.561.7793 phone

415.409.0587 fax

Attention: Teachers

Good News!!!

Students in your school have the opportunity to participate in the Children's Vision First program, which provides **free eye exams and glasses** for our most vulnerable children.

Children are eligible for the Children's Vision First free vision care program if they:

- Have failed the school based vision screening
- Have economic need and **no health insurance of any kind that covers eye exams and glasses**

Making Referrals:

- Make sure the child qualifies: **Has no health insurance and is in economic need.**
- Along with the standard school notification, every child who fails the school vision screening should be sent home with a Children's Vision First "Free Eye Care" letter. This letter is only a tool to help identify children who qualify for our program. Teachers should follow up and collect these letters and return them to the school nurse or health clerk. (Unless it is the teacher who will be filling out the Referral Forms)
- Verifying eligibility requirements with the parent/guardian **by phone is equally acceptable.**
- **Once a child is qualified a Children's Vision First Referral Form is filled out and faxed to Children's Vision First: 415.409.0587** Nurses and vision screeners usually fill out and fax the Children's Vision First Referral Form, however, at some schools it is the teacher who fills out and faxes the Referral Form.
- **Any way you establish that a child is qualified is valid.** (Phone or collect info thru "Free Eye Care" sent home to parents)
- **The Referral Form is all we want or need.**
- **For all grades not being screened,** it is up to the teacher to make sure that any children suspected of having vision problems are brought to the attention of the vision screening team for testing.

What Happens Next?

- When the Referral Form is received by Children's Vision First, a doctor is assigned and a letter with instructions for contacting the doctor is mailed home to the child's parent/guardian.
- A copy of this letter will be faxed to the referrer for record keeping and follow up.
- The **parent must call** their assigned doctor to schedule the appointment for an exam.
- If eyeglasses are prescribed, Children's Vision First manufactures quality new glasses and sends them to the doctor for dispensing. **All doctor services and Children's Vision First eyeglasses are FREE OF CHARGE.**

Follow-up with parents/guardians in the process of verifying insurance and making and keeping doctor appointments is extremely helpful. Better vision is one of the easiest things we can do to improve a child's potential.

Nurse/Vision Screener: _____ Phone: _____

For further information and/or to obtain the Referral Form, please contact the Nurse of the Day at **415.242.2615**, or call Children's Vision First at 415.561.7793.

Keeping CHILDREN in focus

Children's Vision First

(Formerly JVQ California)

1007 General Kennedy Ave. Suite 210

San Francisco, CA 94129

415.561.7793 phone

415.409.0587 fax

Guidelines for School Nurses and Health Clerks

Children are eligible for the Children's Vision First free vision care program if they:

- Have failed the school based vision screening
- Have economic need and **no health insurance of any kind that covers eye exams and glasses**

Who can make a Referral?

- Any school employee who can verify the child's eligibility can make referrals to our program. Generally school teachers, health clerks, nurses and secretaries make referrals to Children's Vision First.

How do I make a Referral?

1) Make sure the child qualifies: Has no health insurance and is in economic need.

- Along with the standard school notification, every child who fails the school vision screening should be sent home with a Children's Vision First "Free Eye Care" letter. This letter is only a tool to help identify children who qualify for our program. Teachers should follow up and collect these letters and return them to the school nurse or health clerk.
- Verifying eligibility requirements with the parent/guardian **by phone is equally acceptable.**
- Any way you establish that a child is qualified is valid. (phone or collect info thru "Free Eye Care" sent home to parents) **Once a child is qualified just fill out a Referral Form. The Referral Form is all we want or need.**

2) For all children who qualify, fill out a Children's Vision First Form. You only need to fill in the left side of the form with the child's information and your contact information. (It is extremely important to print very clearly)

3) Fax the completed Children's Vision First Referral Form to **415.409.0587**.

What Happens Next?

- When the Referral Form is received by Children's Vision First, a doctor is assigned and a letter with instructions for contacting the doctor is mailed home to the child's parent/guardian.
- A copy of this letter will be faxed to you for record keeping and follow up.
- The **parent must call** their assigned doctor to schedule the appointment for an exam.
- If eyeglasses are prescribed, Children's Vision First manufactures quality new glasses and sends them to the doctor for dispensing. **All doctor services and Children's Vision First eyeglasses are FREE OF CHARGE.**

Important Reminders:

- Each CVF Referral Form must be filled out and signed by school personnel.
- Only refer eligible children. Doctors are *donating* their time. Therefore, you must refer *only* those students who truly qualify. Only *one* exam per calendar year is allowed.

Replacing Broken or Lost Eyeglasses:

- A second pair or a replacement pair for lost or broken glasses may be purchased for \$35.00.

For further information and/or to obtain the Referral Form, please contact Nurse of the Day at **415.242.2615**, or call Children's Vision First at 415.561.7793.

Keeping CHILDREN in focus

Ph: (415) 561.7793
 Fax: (415) 409.0587

CHILDREN'S VISION FIRST

Referral Form

1007 General Kennedy Ave. Suite 210
 San Francisco, CA 94129

Section 1: to be filled out COMPLETELY by school personnel (PLEASE PRINT):

Date: _____ County: _____

School District: _____

Student Name: _____
First Last

Date of Birth: _____ Sex: _____

Grade: _____ Teacher: _____

Parent/Guardian: _____

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Other: (____) _____

Child can get to UC Berkeley School of Optometry Yes No

No Insurance Emergency Medical Only Other Ins.

DISPENSE ONLY Insurance Covers Exam but not Glasses

Language spoken in the home:

English Spanish Cantonese
 Mandarin Vietnamese Portuguese

Does child wear glasses now? Yes No

Visual Acuity Screening
 R: _____ Info: _____
 L: _____

School Name: _____ ES MS HS

Contact: _____

Phone: (____) _____ - _____ ext. _____
 Fax: (____) _____ - _____

Signed: _____
Screener/School Personnel

Eligibility has been Verified by:

Section 2: to be filled out by Children's Vision First Doctor (PLEASE PRINT):

Student Name: _____ County: _____

Dr. _____

Dr. Address _____

Dr. Phone: (____) _____ - _____ Dr. Fax: (____) _____

DISPENSE ONLY - NO EXAM PRESCRIPTION PROVIDED**

Diagnosis (circle all that apply) Exam date: _____

Amblyopia Esotropia Hyperopia Ordering 2nd Pair \$35.00
 Astigmatism Emmetropia Myopia Ordering Frame Only \$12.50*
 Color Blind Glaucoma Strabismus

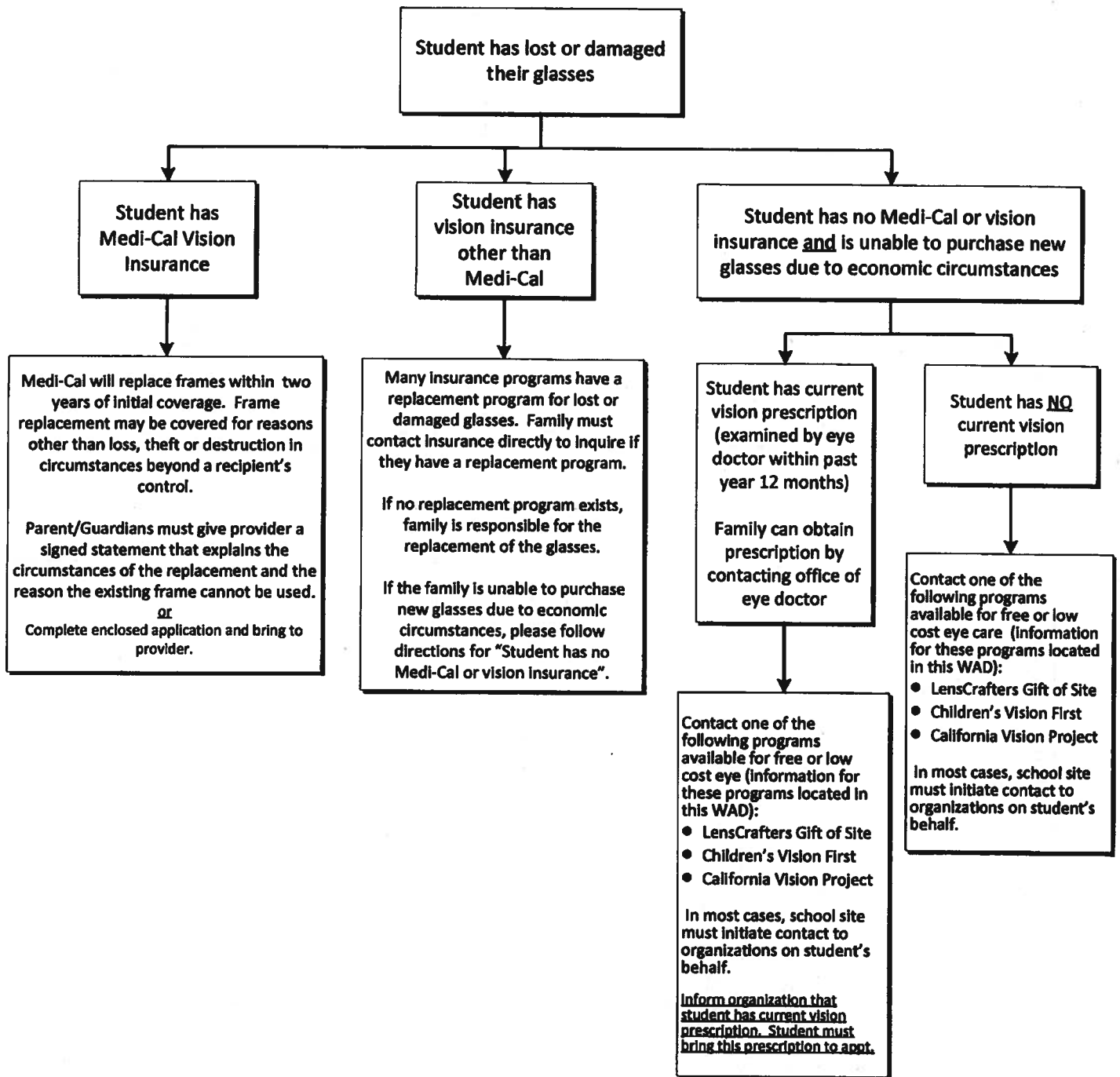
Other: _____

	Sphere	Cyl	Axis	Prism	Direction	Base Curve	Lens type	
R							SV	
L							FT	
	Add	Seg Ht	OC Ht			PD		
R						DISTANCE	TRI	
L						NEAR	OTHER	
FRAME	COLOR			Eye Size	DBL	VQ SUPPLY		
SPECIAL INSTRUCTIONS:							Send To:	
CVF Office	Date received	Dr. Info: Parent		School				
Use Only:	Faxed to Dr:	Faxed to Lab:		Dispensed				

To Order 2nd Pair: Doctor Mails
 2nd Referral Form with Check
 to Children's Vision First

* \$12.50 replacement charge does not apply within warranty.
 ** Patient MUST bring current prescription

Procedure for Replacement of Lost or Damaged Glasses for SFUSD Students



Eye Appliances

This section contains general information about eyeglasses and contact lenses and program coverage (California Code of Regulations [CCR], Title 22, Section 51317

Lost, stolen, broken or significantly damaged eye appliances may not be replaced unless a recipient or recipient's representative supplies the provider with a signed statement. The statement must certify that a loss, breakage, or damage was beyond the recipient's control and must include the circumstances of the loss or destruction and the steps taken to recover the lost item. A recipient's signed statement must be retained in the recipient's file for at least three years.

Date: _____

Dear Doctor _____

The following explains the circumstance of the lost/stolen/broken glasses:

Parent/ Guardian signature

Address _____

California Vision Project (CVP)

2415 K Street, Sacramento, CA 95816

Telephone: (916) 441-3990, Fax: (916) 448-1423

Call toll-free: 1-800-877-5738

GUIDELINES

The California Vision Project is a 501(c)(3) nonprofit organization that provides low-income, working, uninsured, families with free comprehensive eye exams and glasses. Services are provided by volunteer optometrists and may not be available in all areas.

Patient Eligibility and Benefit Information:

Patients are eligible to receive a free comprehensive eye examination and prescription spectacles (if necessary) if the following requirements are met (*NO EXCEPTIONS WILL BE MADE*):

- At least one adult in the household must be employed and working (full-time or part-time)
- The applicant must have no public or private insurance that covers eye exams or glasses
- Applicants must not have had an eye exam in the last 2 years
- Applicants are low income and unable to pay for eye care
- \$10.00 administrative fee (per person) must be included with application

Setting the CVP Patient Appointment:

- Eligible patients will be assigned to a volunteer doctor if there is one available in or near their area.
- Qualified CVP patients receive a letter with their volunteer doctor's name, address and phone number.
- Patients are asked to make an appointment upon receipt of the notification letter. Failure to schedule an appointment within 60 days of the date of the assignment letter will result in disqualification from the Project.
- Volunteer doctors will also receive a letter on a monthly basis, listing patients who have been assigned to them; staff may contact the CVP patient directly to schedule an appointment.
- Patients are warned about not keeping their appointment. They are notified that if they miss their appointment they may be disqualified from the Project.

Processing the Application:

- Applications are processed in the order that they are received and may take from two or up to four months to process.
- The \$10.00 administrative fee is non-refundable except in the case that the patient is determined eligible and the Project does not have a volunteer doctor available in their area.
- Requests to be assigned to a particular volunteer doctor will be considered, but can not be promised.

If a Prescription is Necessary:

- Glasses processed through this Project must be ordered through the doctor's office that the patient is examined through.
- Frames may be limited.
- The patient is limited to only one pair of glasses.
- Glasses must be processed within one month of the patient's examination date.
- Only single vision or bifocal (ST 28) with clear lenses made from CR-39 are covered by this Project.

CALIFORNIA VISION PROJECT (CVP) APPLICATION FORM
 The California Vision Project provides free eye exams to eligible low-income working families.
 Services are donated by volunteer optometrists throughout California.

Eligibility requirements: All eligibility requirements must be met in order to qualify (PLEASE READ)

- At least one adult in the household must be employed (full-time or part-time);
- The person(s) seeking an eye exam must have no public or private insurance that covers eye exams;
- Applicants must not have had an eye exam in the last 2 years; and
- Applicants are low-income and are unable to pay for eye care.
- \$10.00 non-refundable administrative fee (per person) must accompany the application. Check or money orders can be made payable to "The California Vision Foundation."

Please answer all questions below. Verification may be requested.

1. Is anyone in your household currently employed (full-time or part-time)? Yes No
2. What is the total number of people in your household (living with you, including yourself)? _____
3. What was your household's approximate gross annual income before taxes and deductions? _____
4. How far are you able to travel for your appointment? _____ miles
 Please list any particular cities that you would be able to travel to for your appointment: _____

List all family members who are applying for a free eye exam:

Name	Date of Birth	Has this person had an eye exam in the last two years?	Does this person have any private or government insurance that covers eye exams?
1. _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Home address: (Please print)

Address _____
 _____ Apt. # _____
 City _____
 State _____ Zip _____
 Daytime telephone number () _____ - _____

Employer address: (Please print)

Address _____

 City _____
 State _____ Zip _____
 Work telephone number () _____ - _____

Your completed form will be reviewed to determine your eligibility. Eligible patients will be notified by mail and will receive a complete eye exam without cost if a volunteer is available in your area.

Mail this completed application to:
California Vision Foundation
2415 K Street, Sacramento, CA 95816
 If you have any questions please contact Megan Gowin or Michelle Harvey at (800) 877-5738.

FORMULARIO DE SOLICITUD DEL PROYECTO DE LA VISIÓN DE CALIFORNIA (CVP)
 El Proyecto de la Visión de California ofrece exámenes de vista sin cargo a familias de trabajadores de bajos ingresos que cumplen con ciertos requisitos.
 Los servicios son donados por optometristas voluntarios de toda California.

Requisitos que debe cumplir el solicitante: Todos los requisitos de la elegibilidad se deben cumplir para calificar
 (POR FAVOR LEER)

- Al menos un adulto de la casa debe tener trabajo (full-time o part-time);
 - La persona o las personas que soliciten el examen de vista no podrán tener seguro público ni privado que cubra el examen de vista;
 - El solicitante no deberá haberse realizado un examen de vista en los últimos dos años; y
 - Los solicitantes son de bajos ingresos y no pueden pagar la atención oftalmológica.
- Un cargo de \$10.00 administrativo (por persona) tiene que acompañar la aplicación para ser procesada. Cheque o money orders pueden ser escritos a "The California Vision Foundation"

Por favor, responda todas las preguntas. En algunos casos podrá solicitarse verificación.

1. ¿Alguna persona de su hogar trabaja actualmente (full-time o part-time)? Sí No
2. ¿Cuánta gente vive en su casa con usted, incluido usted? _____
3. ¿Cuál fue el ingreso anual bruto aproximado de su hogar antes de impuestos y deducciones? _____
4. ¿Cuán lejos puede viajar para su cita con el oftalmólogo? _____ millas.
 Por favor indique algunas de las ciudades específicas a las que podría viajar para su cita con el oftalmólogo:

Indique quiénes son los miembros de la familia que solicitan un examen de vista gratis:

Nombre:	Fecha de nacimiento	¿Esta persona se hizo un análisis de la vista en los últimos dos años?	¿Esta persona tiene seguro privado o del gobierno que cubra exámenes de la vista?
1.	/ /	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
2.	/ /	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
3.	/ /	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
4.	/ /	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No

Dirección del solicitante: (En letra de molde)

Dirección _____

_____ Nro. de Apto. _____

Ciudad _____

Estado _____ Código postal (Zip) _____

Nro. de teléfono durante el día () _____

Dirección del empleador: (En letra de molde)

Dirección _____

Ciudad _____

Estado _____ Código postal (Zip) _____

Nro. de teléfono del trabajo () _____

Se examinará su formulario completo para determinar si usted cumple con los requisitos. Si los cumple, recibirá una notificación por correo y recibirá un examen de vista integral sin costo si existe un voluntario disponible en su zona.

Envíe este formulario de solicitud completo por correo a:

California Vision Foundation
 2415 K Street, Sacramento, CA 95816

Si tiene alguna pregunta, por favor contacte a Megan Gowin o Michelle Harvey al número (800) 877-5738.



San Francisco Unified School District
Student Support Services Department
1515 Quintara St.
San Francisco, CA 94116
415/242.2615
Fax: 242.2618
[Http://www.healthiersf.org](http://www.healthiersf.org)

Lenscrafters One Sight Program of California

Attn: One Sight Coordinator

Fax: _____

Dear One Sight Coordinator:

I would like to introduce and refer a student to your One Sight Program. I believe that he/she could greatly benefit from the services that LensCrafters One Sight Program of California has generously offered to the students of San Francisco Unified School District. Unfortunately, some of our students are not insured for vision coverage and the need for eye examinations and glasses is so important for their success in learning. Your service is very much appreciated.

Below you will find pertinent information regarding the student I am referring. Please let me know if you need further information. Thank you on behalf of the children and families of San Francisco.

Name/Title of Referring Staff Member

School Site

Phone Number *Fax Number*

Date of Referral

Students Name _____	Date of Birth _____
Home Address _____	
Parent/Guardian Name _____	Phone _____
Language Spoken at Home _____	
School _____	School Tax ID _____

ONE SIGHT PROGRAM

Each of the LensCrafters/EyeExam of California stores donates 2-3 free eye exams and eyeglasses per month for students in need of eye exams and new glasses. This program is on-going through out the year.

When Most stores set aside one day per week for One Sight appointments. Stores should be contacted directly for schedule

Eligibility

- Students have either failed the school based vision screening or have demonstrated a need for vision care.
- Family has economic need and no health insurance that covers eye exams and/or glasses, or
- Family has economic need and has vision insurance but has lost/damaged their glasses and is unable to get new glasses under their current insurance plan.

Procedure

- Contact the One Sight Coordinator at one of the LensCrafters/EyeExam of California stores listed below, request an appointment.
- Complete student referral form (complete with school tax ID number) and fax to LensCrafters.
- Parent or Guardian of student needs to contact store directly to confirm appointment.

Participating Stores

LENSCRAFTERS, MARKET STREET
685 MARKET STREET
SAN FRANCISCO, CA 94105
Ph: (415) 896-0680 Fax: (415) 896-0352

LENSCRAFTERS, STONESTOWN GALLERIA
3251 20TH AVENUE SPACE 219
SAN FRANCISCO, CA 94132
(415) 566-9199

LENSCRAFTERS, PINE & BATTERY
100 BATTERY STREET
SAN FRANCISCO, CA 94111
(415) 399-1473 Fax: (415) 399-1960

LENSCRAFTERS, 280 METRO CENTER
53 COLMA BLVD #F2
COLMA, CA 94014
(650) 992-2700 Fax (650) 992-3215

LENSCRAFTERS, SERRAMONTE CENTER
5 SERRAMONTE CENTER
DALY CITY, CA 94015
(650) 992-1615 Fax (650) 992-1617

LENSCRAFTERS, THE SHOPS AT TANFORAN
1150 EL CAMINO REAL #265
SAN BRUNO, CA 94066
(650) 583-8693 Fax (650) 583-2097

Children's Vision First
(Formerly JVQ California)
1007 General Kennedy Ave. Suite 210
San Francisco, CA 94129
415.561.7793 phone
415.409.0587 fax

Attention: Teachers

Good News!!!

Students in your school have the opportunity to participate in the Children's Vision First program, which provides **free eye exams and glasses** for our most vulnerable children.

Children are eligible for the Children's Vision First free vision care program if they:

- Have failed the school based vision screening
- Have economic need and **no health insurance of any kind that covers eye exams** and glasses

Making Referrals:

- Make sure the child qualifies: **Has no health insurance and is in economic need.**
- Along with the standard school notification, every child who fails the school vision screening should be sent home with a Children's Vision First "Free Eye Care" letter. This letter is only a tool to help identify children who qualify for our program. Teachers should follow up and collect these letters and return them to the school nurse or health clerk. (Unless it is the teacher who will be filling out the Referral Forms)
- Verifying eligibility requirements with the parent/guardian **by phone is equally acceptable.**
- **Once a child is qualified a Children's Vision First Referral Form is filled out** and faxed to Children's Vision First: 415.409.0587 Nurses and vision screeners usually fill out and fax the Children's Vision First Referral Form, however, at some schools it is the teacher who fills out and faxes the Referral Form.
- Any way you establish that a child is qualified is valid. (Phone or collect info thru "Free Eye Care" sent home to parents)
- **The Referral Form is all we want or need.**
- For all grades not being screened, it is up to the teacher to make sure that any children suspected of having vision problems are brought to the attention of the vision screening team for testing.

What Happens Next?

- When the Referral Form is received by Children's Vision First, a doctor is assigned and a letter with instructions for contacting the doctor is mailed home to the child's parent/guardian.
- A copy of this letter will be faxed to the referrer for record keeping and follow up.
- The **parent must call** their assigned doctor to schedule the appointment for an exam.
- If eyeglasses are prescribed, Children's Vision First manufactures quality new glasses and sends them to the doctor for dispensing. All doctor services and Children's Vision First eyeglasses are **FREE OF CHARGE.**

Follow-up with parents/guardians in the process of verifying insurance and making and keeping doctor appointments is extremely helpful. ***Better vision is one of the easiest things we can do to improve a child's potential.***

Nurse/Vision Screener: _____ Phone: _____

For further information and/or to obtain the Referral Form, please contact the Nurse of the Day at **415.242.2615**, or call Children's Vision First at 415.561.7793.

Keeping CHILDREN in focus

OF CALIFORNIA

A LICENSED VISION HEALTH CARE SERVICE PLAN

PATIENT INFORMATION Please Complete at Each Annual Examination (Please Print)

Mr. Master Last Name _____ First Name _____ Initial _____ Sex Male Female Birthdate _____ Age _____

Mrs. Oc. _____

Ms. _____

Home Address _____ City _____ State _____ Zip _____

Preferred Telephone Number () _____ Home Work Cell (circle option) _____ Secondary Telephone Number () _____ Home Work Cell (circle option) _____

We use these calls to remind patients of their appointments. We will use the phone number you provide and the cell one on line or in-person.

Language Preference: English Spanish Chinese Vietnamese Other _____

Do you need assistance from an interpreter? Yes No

Race: White African American Hispanic Asian/Pacific Islander Other _____

Employer Name _____ Employer Address _____ City _____ State _____

Your Occupation _____ Referred By _____

Will you be using any vision benefits or programs? No Yes If yes, please fill in the information below.

Vision Plan Name _____ Number ID # _____ Insurer's Name _____ Patient's Relationship to Insured _____

Would you like to be billed for your services today through the LENS-CRAFTERS account? Yes No

* Note to Technicians: if yes, please fill out LENS-CRAFTERS account application.

Print the no-charge claim for any plan under which we are provided. If you have a question about using plans for which we are provided, please call the number on the back of this form.

Are you interested in looking at eyeglasses at LensCrafters today? _____

- Do you have? (please check all that apply)

<input type="checkbox"/> eyestrain	<input type="checkbox"/> pain	<input type="checkbox"/> double vision
<input type="checkbox"/> dry eyes	<input type="checkbox"/> itchy eyes	<input type="checkbox"/> blurred vision with glasses or contacts
<input type="checkbox"/> floaters	<input type="checkbox"/> flashes of light	<input type="checkbox"/> severe or frequent headaches
<input type="checkbox"/> frequent neck and shoulder pain		
 - Name of your primary physician: _____
 - Age of present glasses: _____ Date of last physical: _____ HMO Member? No Yes
 - Have you been examined at EYEXAM of California before? _____ Date of last eye exam: _____
 - Have your eyes been dilated before? No Yes Which Office: _____
 - Have you had retinal photographs taken before? No Yes When: _____
 - Do you or any blood relatives (grandparents, parents, brothers, sisters, children) have? (please check all that apply)

	Self	Blood Relative		Self	Blood Relative
retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
cataracts	<input type="checkbox"/>	<input type="checkbox"/>	thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	lung disease	<input type="checkbox"/>	<input type="checkbox"/>
high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	<input type="checkbox"/>
 - Are you pregnant? (if applicable) No Yes
 - Are you being treated for any medical condition? No Yes Please List _____
 - Are you taking any medications? No Yes Please List _____
 - Are you allergic to any medication including eye drops? No Yes Please List _____
 - Do you have or have you ever had any eye disease, injury or surgery? No Yes
- If yes please explain: _____

PATIENT VERIFICATION

The patient history information that I have provided above is accurate and complete to the best of my knowledge.

Signature (if under 18 years of age, parent signature required) _____ Date _____