

General Information for Planning an iSee Event

About the iSee program

The in School Eye Exam (iSee) program is the signature initiative of the Ohio Optometric Foundation (OOF) aimed at improving vision care for at-risk children throughout Ohio. OOF works in conjunction with school districts to organize a two-day school-based event where eye exams and eyewear are provided at no charge to students. OOF staff works with school nurses to provide exams to children identified as needing follow-up vision care from school mandated vision screenings.

Studies show that nearly 50% of students referred for additional care from school vision screenings do not receive needed follow-up care with an eye care provider.¹ With 80% of learning coming through the visual system, these children are at a significant disadvantage when it comes to learning and succeeding in school. If a vision problem is not identified and corrected at an early age, a child may have permanent, uncorrectable vision loss that could potentially limit opportunities throughout his or her lifetime.² Furthermore, a significant percentage of children on Individualized Education Plans and children who are academically and behaviorally at-risk, have vision problems that are either undetected or untreated.³

The iSee program bridges the gap by bringing eye exams *and* eyewear directly to schools. iSee events are provided at no cost. The services, equipment, and custom eyewear are generously donated. Doctors of optometry and optometric staff volunteer their time to provide the exams and information for follow-up care, if needed.

Event Criteria and Specifics

- The program is available to students' enrolled in pre-K through 12th grade, and is not open to the public or adults.
- Typically, 60-80 students can be seen during the two-days of exams.
- A school/district must guarantee participation of a minimum of 45 students.
- The exam portion is held for two days (typically, Wednesday and Thursday) at one location.
- Equipment needs to be set up the day before the event and may be broken down the day after (4 days total).
- The location needs a darkened space for two exam lanes and pre-test equipment, as well as an area for activities for children waiting for exams.
- Post-event, eyeglasses are delivered to school and dispensed to students by a licensed optician.
- Allow eight weeks for even planning and coordination.
- Students must complete the following enclosed forms prior to iSee event:
 - Patient consent form
 - Health history
 - Multi-media release form

Please complete the iSee request form, and review the enclosed School Nurse Coordination Checklist for further details on the school district's responsibilities.

or questions, contact Dr. Tracey Needham, via email needham@ameritech.net or by phone (419) 297-7796 (mobile).

¹ Donohue, S., Johnson, T., Leonard-Martin, T. Screening for Amblyogenic Factors Using a Volunteer Lay Network and the MTI Photoscreener; *Ophthalmology*, 2000; 107: 1637-44.

Preslan, M., Novak, A., Baltimore Vision Screening Project; *Ophthalmology*, 1998; 105: 150-153.

² Vision In Preschoolers Study (Professor Charles Sheard The Ohio State University, Department of Physics). Centers for Disease Control and Prevention, (2007). *Improving the Nation's Vision Health: A Coordinated Public Health Approach*.

³ Walline, J.; Carder, E; *Vision Problems of Children with Individualized Education Programs; J Behav Optom*, 2012, 23 (4): 87-93.
Johnson, R.A.; Nottingham, M.S.; Zaba, J.; *The Visual Screening of Title 1 Reading Students; J Behav Optom*, 2000, 4 (1): 3-6.

School Nurse Coordination Checklist

1. Complete iSee request form on www.ohiooptometricfoundation.org.
2. Initial logistics planning
 - a. Coordinate date of project with the Ohio Optometric Foundation: Wednesday/Thursday is preferred.
 - b. Arrange for space requirements and obtain appropriate approvals from school administrators.
 - c. For events that are to be held inside the school building:
 - i. Ideal location has two areas in close proximity but with privacy concerns considered.
 - ii. Exam areas should be at least 5ft X 16ft.
 - iii. Additional areas needed for checking in students, pre-test and frame selection. This can all be done in one general area if needed with space requirements of 10ft X 20ft.
 - i. Minimal student traffic is preferred.
 - ii. Access to additional tables, chairs for students and volunteers, extension cords and room dividers. Access to a copier so we can provide you with copies of the exam for your records.
 - iii. Areas must be available for equipment set-up the day before the event and equipment removal the day after the event.
 - iv. Areas must be able to be **secured/locked** when the event is not in progress.
3. Ideally, students enrolled in iSee event are those who failed vision screening within 6 months prior to the event. If need be, conduct screenings no later than 2 weeks before iSee event date. Copies of screening results should be made available (**TO WHOM?**) prior to the event and included with the exam and history form so it can be used during the exam with the doctor.
4. Send parental consent forms and history forms home to be filled out by parents. Consider developing a cover letter to explain the project to accompany the consent forms and history forms. **Consent forms must be signed by a parent or legal guardian for all students. NO EXCEPTIONS!**
5. Priority should be given to low income students without insurance. Many Medicaid students have been seen, however.
6. A minimum number of 45 students is required for the program. We will need an estimated final count 7 to 10 days before the event.
7. Develop custom appointment schedule based on school hours, keeping bus schedules and lunches in mind. Typically, two students can be seen every twenty to thirty minutes.

8. Determine what volunteers the school or parent groups can provide on the examination dates. Determine a method to dismiss student from their classroom and arrive at the examination site. Scheduling the students around their lunch period will need to be determined.
9. If students are to be brought in from other buildings within the school district, the school must make those arrangements. The OOF does not provide transportation for students.
10. Eyeglasses will be brought to the school and dispensed to the students by a volunteer optometrist or optician within 2-3 weeks following the examinations. You will be provided with information to contact the volunteer doctor or optician to make arrangements for a mutually acceptable time and place to dispense the glasses to the students. Assistance may also come from OOF staff depending on availability.



Patient Consent Form

I hereby consent to receive a comprehensive OR intermediate eye exam, and, if prescribed, lens and frame services through the Ohio Optometric Foundation.

I acknowledge that I have been informed of the risks, benefits, and alternatives to receiving a comprehensive or intermediate eye exam and all of my questions have been addressed.

A complete eye exam may include dilating drops that cause the pupils to enlarge to allow proper viewing of the back of the eye. Complications for dilation are extremely low and can include, but are not limited to: an acute rise in intraocular pressure, a raise in blood pressure, a change in heart rate, or an allergic reaction to the drop.

By signing this document, you are consenting to any and all procedures the Optometrist deems necessary and understand that complications may arise.

I certify that I am of legal age and that I have read and understand this form, and that this form has been voluntarily executed on the date indicated below.

Patient Name: _____ (print name please)

Parent/Guardian Name: _____ (print name please)

Patient OR Parent/Guardian Signature: _____ Date: _____

About the Ohio Optometric Foundation

The Ohio Optometric Foundation is a 501(c)(3) nonprofit organization, whose mission is to improve the visual health and welfare of Ohio's citizens. The Ohio Optometric Foundation achieves its goals through programs that improve the vision and eye health of the citizens of Ohio; provide opportunities and resources for children and underserved individuals to obtain eye health care; and promote public awareness of the importance of a lifetime of comprehensive eye care.

STAFF USE ONLY:

_____ Patient refused to accept this form

_____ Patient accepted a copy of this form, but refused to sign it

Date: _____ Patient Name: _____ Staff Signature _____

Ohio Optometric Foundation Confidential History

Parents or Guardians: Please complete every question on this form. Do not leave any question blank. You may write “not applicable,” “N/A”, “unknown” or “none” if a question does not apply to your child. This information is important to ensure a complete eye examination. **A completed form is required in order for your child to participate in this program.**

Child's name: _____	Age: _____ Birthdate: _____
Child's Social Security Number: _____	Teacher name: _____
Parent/Guardian's Name: _____	Grade: _____ School: _____
	Home/Mobile Phone#: _____
Address: _____	
Street address	Apt# City State Zip
Is your child covered by Ohio Medicaid? (circle one) Yes No	
Other Vision Insurance: _____ Other Medical Insurance: _____	
Tell Us About Your Child's Vision and Eye Health History	
What is the date of your child's last eye exam? _____ Eye Doctor's name _____	
<p>Please check any of the following problems your child is <u>currently</u> having:</p> <p><input type="checkbox"/> Distance vision is blurry <input type="checkbox"/> Headaches <input type="checkbox"/> Eyestrain</p> <p><input type="checkbox"/> Double vision <input type="checkbox"/> Near vision is blurry <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Burning <input type="checkbox"/> Watering <input type="checkbox"/> Spots or Floaters</p> <p><input type="checkbox"/> Flashes of Light <input type="checkbox"/> Glare <input type="checkbox"/> Eye pain</p>	<p>Please check any of the below if your child has ever had:</p> <p><input type="checkbox"/> Eye infection <input type="checkbox"/> Eye Surgery</p> <p><input type="checkbox"/> Eye Injury <input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Patching or vision therapy <input type="checkbox"/> Head injury</p> <p><input type="checkbox"/> An eye turn or a “lazy” eye</p> <p><input type="checkbox"/> Other eye problem: _____</p>
Tell Us About Your Child's Medical Health History	
What is the date of your child's last physical exam? _____ Doctor's name _____	
<p>Check any of the below if your child has been diagnosed with any of the following:</p> <p><input type="checkbox"/> Developmental delay/disorder</p> <p><input type="checkbox"/> Behavioral disorder</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Breathing problems (example: asthma)</p> <p><input type="checkbox"/> Heart problems</p> <p><input type="checkbox"/> Digestive system problems</p> <p><input type="checkbox"/> Thyroid disorder</p> <p><input type="checkbox"/> Blood disorder</p> <p><input type="checkbox"/> Neurologic disorder</p> <p><input type="checkbox"/> Skin disorder</p> <p><input type="checkbox"/> Bone/Muscle disorder</p> <p><input type="checkbox"/> Ear/Nose /Throat disorder</p> <p><input type="checkbox"/> My child does not have any medical health problems</p>	<p>Check any of the boxes below if anyone in <u>your child's immediate family</u> has been diagnosed with any of the following:</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Macular Degeneration</p> <p><input type="checkbox"/> Retinal Detachments/disorder</p> <p><input type="checkbox"/> Thyroid disorder</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> High Blood Pressure</p>
<p>List any medications your child is currently taking. (Include any inhalers, eye drops, or over the counter medications.) Write “none” if your child is not taking any medications.</p> <p>_____</p> <p>_____</p>	<p>List your child's medication allergies, food allergies, seasonal or environmental allergies below. Write “none” if your child has no known allergies.</p> <p>_____</p> <p>_____</p>



Ohio Optometric Foundation Media Authorizations and Release

(Photo, Video, and Testimonial)

I hereby authorize the Ohio Optometric Foundation, and/or its representative(s) (the "Foundation"), to use, disclose, publish, copyright and/or otherwise make available my information, personal image, testimonial or other materials, in whole or in part, to the general public for purposes of community relations initiatives, event announcements and promotions, social media outreach, advertising, training activities, Foundation programs, and other communications activities, including putting this material on the Foundation's web page. This Authorization and Release covers all forms of media, including print, digital, and electronic media in every form and forum.

I understand that:

- This Authorization and Release has no expiration. A copy of this Authorization and Release is valid as the original. I hereby waive the right to inspect and/or approve the finished copy of any print, digital, or electronic media that may be produced using my information, image, testimonial or other materials or eventual use to which it might be applied.
- No money will ever be due to me from the Foundation or any source as a result of the publication, use, or disclosure of my information, personal image, testimonial or other materials that I have authorized to be used or disclosed by this Authorization and Release.
- I forever release and discharge Foundation from all claims and demands arising out of or in connection with any and all rights I may have or may have had in my information, personal image, testimonial or other materials that I have authorized to be used and disclosed in this Authorization and Release including, but not limited to, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights.

Personal Signature:

By signing below, I acknowledge this Authorization and Release is a voluntary contribution and that I have read this Authorization and Release carefully and fully understand it.

Signature: _____ Date: _____

If Patient is a minor,

Parent/Guardian

Signature: _____ Date: _____