JORDAN VALLEY
COMMUNITY HEALTH CENTER

Jordan Valley Optometry Mobile Unit

The information requested is very important. In order for your child to receive vision care provided by the Jordan Valley staff, you will need to read this form carefully and complete both sides for your child. Please make your answers as complete and accurate as possible. This will help us provide the best possible vision care for your child. This information form becomes part of our permanent record and will be held in strict confidence. If you are unable to complete this form by yourself, please ask for assistance. Please contact your school nurse or the Jordan Valley Clinic – Optometry Assistant at 417-831-0150 Extension 1229, with any questions.

DATE:______________SCHOOL: ____ GRADE:__________ TEACHER:___________

CHILD'S NAME: ____
FIRST M.I. LAST

SOCIAL SECURITY #: _____________-________-_____________ DATE OF BIRTH: ____________________________________

AGE: ______ RACE: ______________________ PREFERRED LANGUAGE: ________________ SEX: MALE FEMALE

ADDRESS: STREET____CITY: ______________________ ZIP: __________________

LEGAL GUARDIAN NAME: ____ DATE OF BIRTH:________________________

ADDRESS: STREET____CITY:______________________ZIP:__________________

RELATIONSHIP:____

HOME PHONE #: _______________________ WORK#:_________________________ CELL# ____________________________

PEDIATRIC PAST VISION HISTORY

Please check any condition that applies to your child or any members of their immediate family:

Condition	Self	Family	Condition	Self	Family	Condition	Self	Family
❑ Diabetes	____	____	❑ Eye Surgery	____	____	❑ Lazy eye	____	____
❑ High blood pressure	____	____				❑ Double vision	____	____
❑ Cataracts	____	____	❑ Glaucoma	____	____	❑ Blindness	____	____
❑ Heart problems	____	____	❑ Loss of vision	____	____	❑ Head/Eye injury	____	____
❑ Respiratory problems	____	____	❑ Retinal detachment	____	____	❑ Headaches	____	____
❑ Thyroid problems	____	____						

Medications:
1.____
2.____
3.____
4.____
5.____

Allergies:
1.____
2.____
3.____
4.____
5.____

Reason for seeking vision care for your child:

Routine check-up____ Vision problems ____ Other (please specify) _______________________________
Has your child seen an eye doctor before? Yes _________ No______________
If yes, date of the last eye exam? ______________________________
Has your child ever worn glasses? Yes ________ No ______________
Have they ever worn contacts? Yes_________ No ______________

Please have your child bring glasses (and old prescription if available) on the day of eye exam.
Please leave contacts out on the day of eye exam.

Please note the federal government requires us to ask you for this information and it will be used for government reporting purposes only. Your name or any other identifying information will not be disclosed and we will not use this information for any other purpose.

Please circle your family size and the range of your annual income.

Family Size	A	B	C	D
1	$0 - $ 11,770	$ 11,771 - $ 17,655	$ 17,656 - $ 23,540	$ 23,541 or greater
2	$0 - $ 15,930	$ 15,931 - $ 23,895	$ 23,896 - $ 31,860	$ 31,861 or greater
3	$0 - $ 20,090	$ 20,091 - $ 30,135	$ 30,136 - $ 40,180	$ 40,181 or greater
4	$0 - $ 24,250	$ 24,251 - $ 36,375	$ 36,376 - $ 48,500	$ 48,501 or greater
5	$0 - $ 28,410	$ 28,411 - $ 42,615	$ 42,616 - $ 56,820	$ 56,821 or greater
6	$0 - $ 32,570	$ 32,571 - $ 48,855	$ 48,856 - $ 65,140	$ 65,141 or greater
7	$0 - $ 36,730	$ 36,731 - $ 55,095	$ 55,096 - $ 73,460	$ 73,461 or greater
8	$0 - $ 40,890	$ 40,891 - $ 61,335	$ 61,336 - $ 81,780	$ 81,781 or greater
9	$0 - $ 45,050	$ 45,051 - $ 67,575	$ 67,576 - $ 90,100	$ 90,101 or greater
10	$0 - $ 49,210	$ 49,211 - $ 73,815	$ 73,816 - $ 98,420	$ 98,421 or greater

INSURANCE

CHILD IS COVERED BY MEDICAID: YES NO MEDICAID #: ______________________

VISION INSURANCE: YES NO

NAME OF INSURANCE: _________________________________POLICY#__________________ GROUP#________________

INSURANCE BILLING ADDRESS:____

NAME OF POLICY HOLDER: ____ DATE OF BIRTH: __________________

SOCIAL SECURITY #: _____________ -_________ -_____________ RELATIONSHIP:_________________________________

AUTHORIZATION FOR DISCLOSURE: I give express permission to discuss with the individual(s) I have listed my child's health and financial information:

Name______________________________ Relationship ____________________ Phone # ________________________

Name______________________________ Relationship ____________________ Phone # ________________________

MY SIGNATURE BELOW MEANS:

- I have read and agreed to the above requirements and conditions.
- I give Jordan Valley Optometry staff permission to examine and treat my child ____________________________(child's name) and if necessary, fit them for eyeglasses.
- I understand that these policies apply **only** to services provided by Jordan Valley Community Health Center School-Based Clinics.
- Consent to treat will be valid for one year from date of signature.

Legal Guardian

Signature: ____ Date: _______________________

Printed Name: ____ Email:________________________