



Cardinal Cushing Centers

Dear Parents/Guardians:

In collaboration with New England College of Optometry and local community vision resources, we have continued to offer a Vision Clinic and vision services on our Hanover Campus. This is a wonderful opportunity to obtain vision services for many of our students by doctors who are experienced in the eye care of children, and adults with special needs.

A description of the services to be offered is enclosed, please retain a copy of this information for your records. If you are interested in having your child participate in these services, please review the material and return the signed consent/release form as soon as possible. In addition, if you are not interested in this clinic, please check the appropriate box, and if you choose, indicate the doctor who is following their care, and their last exam date for our records.

Thank you for your time and attention.

Sincerely,

June Smith, OTR/L, Occupational Therapy Department

Claire Lehan, R.N. Director of Health Services

Rev. 3/08

Dear Parents/Guardians:

When and Why Should I have my Child's Eyes Examined?

Approximately three million individuals in the United States have disabilities that can interfere with their ability to work, play, and learn. Many of these have vision and eye problems that are undetected and untreated. Early intervention in eye care is cost-effective for society, prevents the development of secondary problems, and helps facilitate the benefits gained from other rehabilitation and education programs. Our on-site clinic will offer the following advantages to our students.

- Support of staff to communicate symptoms
- Minimal time involved in the clinic
- Carry over of visual recommendations
- Eliminates time to transport student to outside appointments when possible.
- Follow-up can be provided during future clinics

What can you expect when your child is examined by the NEEI/Cardinal Cushing Centers Vision Care Service?

If a child requires an examination by an eye care professional, he/she should be examined by doctors who are experienced in the eye care of children with special needs. The doctor and their staff provide an office setting that allows the child to feel comfortable. This is why the exam will be on-site in the regular and daily supportive environment of the child whenever possible.

The doctor will require information about the child's medical history, family history of medical and eye problems, any medications the child takes, and any allergies or sensitivities to medications.

At the beginning of the examination, the doctor will measure the child's vision with each eye separately, using various methods, depending upon the child's age and abilities. Doing so may involve observing how the individual follows small objects or how well he/she can read letters, numbers or identify small pictures on an eye chart.

Depending upon the reason for the examination, the doctor may examine the child's eye movements, pupillary responses, eyelid and eye socket structures, and front part of the eye. As appropriate, drops may be used to dilate the child's eyes to further determine his/her vision status and the potential need for eyeglasses.

Parents/guardians are more than welcome to attend this evaluation. Please notify the Vision Clinic Coordinator at Ext. 1210 for this request.

The results of this examination will be written in an easy to read report and will be shared with the primary staff at Cardinal Cushing Centers, who are working directly with the student. Upon request, a copy of this evaluation can also be sent to you.

Should you have any further clinical questions based on the Occupational Therapy vision screening, feel free to contact the occupational therapy staff, June Smith or Barb Richardson at Ext. 1210 for further information, or you can visit this website www.covd.org for a wealth of information provided by the College of Optometrists in Vision Development.

We look forward to providing this valuable service to your child.

New England Eye Institute,
the teaching affiliate of the
New England College of Optometry, 1255 Boylston St., Boston, MA 02215
In affiliation with:
Cardinal Cushing Centers, 400 Washington St., Hanover, MA 02339

Consent/Release Form

I, _____, provide permission for _____,
(Parent/Guardian) (Student)

to be evaluated at the New England Eye Institute Vision Clinic held at Cardinal Cushing Centers of Hanover. I voluntarily consent to the performance of examination, diagnostic procedures and/or treatment as deemed necessary or beneficial for their case. This may include photos/videos for clinical and educational purposes. In addition, the student will continue to receive follow-up services or evaluations as deemed appropriate by the vision clinic staff or community vision resources unless otherwise requested.

I understand that any of the above measures, may be performed by an optometrist, ophthalmologist, other qualified specialists, intern, resident, student clinician, or technician under the supervision of an optometrist, or qualified specialist. I understand that as part of their vision examination, pharmaceutical agents may be utilized for the purposes of dilating their eyes. I further understand that the effects of these agents may include blurred vision and sensitivity to light.

I understand that although this service is commonly on-site at Cardinal Cushing Centers of Hanover, that the New England Eye Institute is an independent contractor, and that Cardinal Cushing assumes no financial obligation to follow the results of any evaluation/treatment course. This service is **not** one that is covered under the current tuition rate. Evaluations are scheduled for the above student as soon as possible upon insurance approval by NEEI. New England Eye Institute will work with the patient/guardian and/or patient/representative to seek payment from the appropriate insurance agencies. Mass. Health (Medicaid) covers one exam per year, as well as one pair of glasses/frames per year (for those under 21 years of age).

Parent/Guardian Signature: _____ Date: _____

Address: _____ Telephone: _____

Name (Primary Insurance Policy Holder): _____

Above Subscriber's (not student's) date of birth: _____

Date of last known vision exam: _____

If **NOT** interested, check here ____.

Student will be followed instead by Dr. _____.