Overbrook School for the Blind

Overbrook School for the Blind
6333 Malvern Ave.
Philadelphia, Pa.
215-877-0313 ext 218

Dear Parent or Guardian:

School staff has recommended that your child have a low vision optometric examination. This is advised in order to determine if he or she could benefit from glasses, low vision devices or specialized training. Participation in the Overbrook Low Vision Clinic can also help OSB staff to further refine classroom programming needed to meet the educational needs of your child. Participation also affords you the opportunity to have your questions answered about your child's visual condition and his or her use of vision.

Dr. Sarah Appel, an Optometrist from Salus University, formerly the Pennsylvania College of Optometry, conducts the medical clinics at our school. Dr. Appel specializes in pediatric low vision care. The generosity of donors has allowed Overbrook to offer this valuable service to you free of charge. Donations of any amount however are greatly appreciated and are used exclusively to sponsor additional student participation.

What you can expect when your student participates in the OSB Low Vision Clinic:

1 Prior to the appointment , OSB low vision specialist, reviews your child's medical file and collects information from OSB staff. This information is subsequently shared with Dr. Appel so that she has a well rounded understanding of the impact of your child's visual impairment on their learning and living skills.

2. Prior to the appointment, Marci Graboyes of Salus University will contact you to learn about your child's medical history and any concerns and/or questions you have related to your child's vision. She will set up an official medical record for Dr. Appel and will bring this on the date your child is seen in clinic.

3. During the appointment Dr. Appel completes a low vision optometric examination and determines if your student could benefit from glasses, low vision devices or training to better utilize his or her visual abilities. She will share recommendations with you, your child, and school staff. Parental attendance is encouraged. Many parents have stated that they found the visit to be extremely informative. Appointments last approximately 1 to 1.5 hours. Upon conclusion of the examination the family and school receive a comprehensive report, including all the doctor's recommendations.

If you are interested in having your student participate, please **sign and return the enclosed forms in the pre-stamped envelope. Space is limited and appointments are offered on a first come first serve basis.** You will receive a notice of the appointment date and time.

Sincerely,

JoAnn McNamee
Clinic Coordinator

Permission to Participate in Overbrook Low Vision Clinic

Student_____ **Date:**_____

I give permission for the above named student to participate in the Overbrook Low Vision Clinic which is held on the OSB campus in conjunction with The Eye Institute of Salus University.

My signature gives permission for all of the following during the current school year.

Student evaluation

Follow-up appointment to evaluate new glasses

OSB staff may complete a review of my child's educational and medical records.

Dr. S. Appel and M. Graboyes from Salus University, William Feinbloom Vision Rehabilitation Center may complete a review of my childs' visual, educational and Medical records.

Staff may refer my address and phone number to Marci Graboyes of PCO for Parent/guardian contact information prior to the clinic appointment.

My child may receive eye drops for dilation during the visual examination.
Yes_____ No_____

Clinic staff may photograph and/or videotape my child and/or family members and These pictures may be used in educational and public relations efforts.
Yes☐ No☐

Parent/Guardian Name [print] _____

Parent/Guardian [signature] _____

Date_____

Relationship to child _____

Phone number where you can be reached and best time to call:

Home_____

Cell_____

Work _____

Return completed form ASAP to OSB Low Vision Clinic
215-877-0313 ext 218

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____[name of individual], date of birth_____
Have reviewed a copy of Salus University's Notice of Privacy Practices.
I understand that I am entitled to a copy of the Notice should I desire one.

_____ _____
Signature Individual or Personal Representative Date

_____ _____
Print Name of Personal Representative [if applicable] Relationship of Personal Representative to Individual

If this acknowledgement is signed by someone who is not the individual listed at the top of this form, provide a description of the signer's authority to act for the individual.

FOR COLLEGE USE ONLY:

Salus University made the following good faith efforts to obtain the above-referenced individual's Written acknowledgement of receipt of the Notice of Privacy Information Practices:

[ ] Individual/personal representative was offered copy and individual refused to sign form to acknowledge Receipt of Notice.

[ ] Other:_____

_____ _____
Staff Member Signature Date

_____
Print Name

The Eye Institute

Excellence in Eyecare

www.TEIvision.com

William Feinbloom
Vision Rehabilitation Center
1200 West Godfrey Avenue
Philadelphia, PA 19141-3323

The William Feinbloom Vision Rehabilitation Center
Consent and Release Form

I, _____, having presented myself at the William Feinbloom Vision Rehabilitation Center of Salus University for examination and/or treatment, I do voluntarily consent to the performance of examination, diagnostic procedures, and/or treatments as deemed necessary or beneficial for my case. I understand that any of the above measures may be performed by an optometrist, ophthalmologist, other qualified specialist, intern, or technician under the supervision of either an optometrist, ophthalmologist, or qualified specialist. I further acknowledge that no guarantees have been made to me as to the effect of such procedures on my condition. I also consent to the inspection of the records of my treatment for research or scientific purposes by any person specifically authorized to do so by the Director of the Feinbloom Center.

Patient Information Release:

In the interest of my own eye care, both present and future, I hereby give my consent to the Eye Institute-William Feinbloom Vision Rehabilitation Center for the release of any or all information contained in my records, as may be requested by those engaged in my eye care.

This release is of perpetual duration

_____ _____ _____

Patient Date Witness

Because the patient is unable to sign for the following reason:_____
The above consent and release is given on the patient's behalf by:

_____ _____ _____

Relative/Guardian-Relationship Date Witness

Overbrook School for the Blind
Low Vision Clinic Parent Input Form

Student_____DOB_____Age____

Program_____ Date_____

Family member completing form Relationship to student

[Print name]_____ _____

Date of last eye exam_____

Name of Doctor _____
Address _____
Phone #_____

Medications taken by my child_____

List specific vision problems you would like the Doctor to check:

_____

_____

List any questions you would like answered about your child's vision:

_____

_____

Do you understand your Child's vision problems? Yes No Unsure

Does your child receive any of the following?

OT☐ PT☐ Speech☐ O&M☐ Hearing☐ Other☐___

Does your child's vision interfere with any of the following at home? <u>If so please explain:</u>

Personal care☐
Community activities☐
Interaction with family members☐
Mobility in the home or neighborhood☐

Play/Leisure☐
School work☐
Motor skills☐

_____

_____

Does your child have problems related to lighting? Yes ◯ No ◯
If yes, please describe.

Does your child have:
Eyeglasses: Yes ◯ No ◯ Has but does not use ◯

Do they help? Explain

Sunglasses: Yes ◯ No ◯ Has but does not use ◯

Do they help? Explain

Contacts: Yes ◯ No ◯ Has but does not use ◯

Do they help? Explain

Low vision devices such as magnifiers, telescopes etc.

Yes ◯ No ◯ Has but does not use ◯

Do they help? Explain

Please share any other information that you feel will be helpful.

Will you attend the clinic appointment with your child?
Yes ◯ No ◯

_____
Print name

_____ _____
Signature Date