KanLovKids Clinic Programs

Participation and Consent Form

A KanLovKids Low Vision Collaboration Clinic (LVCC) or Low Vision Collaboration Clinic + (LVCC +) is only intended to determine which low vision devices and strategies will assist children in completing educational goals. Because the clinic does not provide a complete medical examination of the eyes, the doctor recommends that all participating children receive a separate full medical eye examination at least every three years. The clinic doctor is able to provide referrals for full medical eye examinations upon request.

All services of the Kansas State School for the Blind (KSSB) are a part of the public education system of the state of Kansas. Records obtained or produced by KSSB's employees and contractors in connection with these activities become a part of the child's educational records and are protected under state law and the federal Family Educational Rights and Privacy Act (FERPA). Other educational entities are able to disclose relevant educational records to KSSB without additional consent. For additional details on family and student rights related to educational records at KSSB, please see the Student/Parent Handbook on the school's website.

The clinic participant will be scheduled to receive services only after all necessary records are received by KSSB. This consent form is valid for one calendar year from the date it is signed. If the required records are not received within one calendar year, a new consent form will be required.

Authorization for the release and/or discussion of protected health information to be sent to Molly Reardon, Kansas State School for the Blind, KanLovKids Coordinator

Patient Name:_____DOB: _____

Address: _____ City: _____ State: _____ Zip:_____

I, _____ hereby authorize _____

Phone#_____ Fax#_____

to release and/or discuss the following information:

☐ Complete Record OR ☐ Specified Information: _____

To be sent to: Molly Reardon, Kansas State School for the Blind, KanLovKids Coordinator
1100 State Avenue, Kansas City, KS 66102, email: mreardon@kssdb.org or fax: 913-621-2310

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun. This authorization expires one year from today's date.

Signature:_____ Date:_____

Relationship:_____ Email:_____

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TSVI/COMS Form for LVCC and LVCC+

Date: _____

Student Name: _____

Please state why you would like to attend a low vision clinic. Also, any questions you may have for the doctor regarding the student.

Age of Student: _____ Student's Grade: _____ Student's Gender: _____

TSVI's Name: _____ TSVI's Email: _____

COMS Name: _____ COMS Email: _____

Infant/Toddler Contact: _____ Infant/Toddler Email: _____

Agency Name or District Name **AND** USD Number (this information is used for billing and record keeping and must be completed for **ALL** participants 0-21 years of age).

USD/Agency: _____ USD/Agency Contact Name: _____

USD/Agency Contact Email: _____ USD/Agency Contact Phone: _____