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:_____

KanLovKids Clinic Programs

Child and Family History Form

Date: _____ Parent/Guardian Email: _____

Student Name: _____ Date of Birth: _____

Gestational Age: _____ Birth Weight: _____ Multiple Birth:

- ☐ Single
- ☐ Twins
- ☐ Triplets

Past Ocular History

Your child's ocular history (e.g., age of symptoms onset; eye turns; eye surgeries [list and note year]; eye-poking; etc.):

Parent description of functional vision (e.g., response to parent's face; to toys or objects; tracking favorite color, etc.)

Eye medications:

Any significant family ocular history (eye diseases - eye turns, lazy eye, eye patching, thick glasses, medical problems or disabilities in the family, etc.):

Past Medical History

Perinatal History

Mother (e.g., general health of mother during pregnancy; general nutritional status; estimated date of confinement; drugs-alcohol-medications during pregnancy; trauma; infections such as CMV, AIDS, toxoplasmosis, maternal rubella; steroid use; hypertension; pre-eclampsia):

Your child's gestational age at birth. Birth weight. Did the baby move in utero? How was the birth? Was resuscitation required? Other congenital anomalies?

Postnatal History

Nursery stay (retinopathy of prematurity risk factors, especially low birth weight and exacerbated by several factors including; sepsis, transfusions, unstable course, cortical visual impairments risk factors including above, and history of intraventricular hemorrhage):

Current medical problems (seizures, trauma, other congenital anomalies; birthmarks, ADHD, hearing, speech, hospitalization, frequent visits to the doctor, surgeries [please list and note date of], other diagnosis, etc.):

Developmental history: When did your child raise his/her head? Crawl? Walk? Reach/grasp object - when?

Medications:

Allergies:

Educational issues: How is your child performing in early intervention services/school? Explain type of home/school s/he participates in or attends.

Other interventions: What services is your child receiving (e.g., occupational or physical therapy, speech therapy, services from a teacher of students with visual impairments, orientation and mobility, etc.)?

Lawrence, L. M. (2003). Pediatric Low Vision. Project ORBIS International Inc. http://telemedicine.orbis.org/bins/volume_page.asp?cid=1-861-863-862&lang=1

Hatton, D.D., & Campbell, A.F. (2003). Interpreting eye reports. Chapel Hill, NC: Early Intervention Training Center for Infants and Toddlers with Visual Impairments, FPG Child Development Institute, UNC-CH.

Functional Eye Gaze Assessment

Purpose Statement: Eye gaze software is most commonly used to help provide communication for persons who cannot verbally speak. The Functional Eye Gaze Assessment is not addressing communication, rather, elements of the software are being used to assess where the eyes focus on the screen while participating in training activities by recording visual fixations. A camera captures the reflection of an infrared light emitted from the camera and uses that reflection to activate elements on the screen. A heat map, gaze plot and screen recording are produced and can be shared as a summary, along with a video of the student's face. It should be noted that specific calibration to each student is not always completed and different results may be obtained if customized calibration were done.

Disclaimer: This informal assessment activity is used to provide additional observation and insight into the student's functional visual behaviors. Any observations are provided to the educational team as suggestions only and should not be the only data used when making decisions regarding educational assessment, placement or services.

Dr. Linda Lawrence, MD and the Kansas State School for the Blind are gathering the data collected in these assessments to further understand and develop this testing for widespread use. Please mark the appropriate items below to agree to participation in the assessment and sharing of the results. While your child's name, year of birth, image of his/her face and primary visual or medical diagnosis may be collected and stored in a secure database, the sharing of results will not identify your child in any way.

No harmful effects are anticipated in the participation in use of the system or sharing of the collected data.

Please mark **ONE** box in each section below. **EITHER** "I agree"**OR** "I DO NOT consent".

☐ **I agree** for my child to participate in the Functional Eye Gaze Assessment.
☐ **I DO NOT consent** for my child to participate in the Functional Eye Gaze Assessment.

****

☐ **I agree** to the use of the data collected for further development of this test by Dr. Lawrence, and/or KSSB.
☐ **I DO NOT consent** to my child's information being used in any research capacity.

****

☐ **I agree** to photographs/videos of my child to be used for education of and/or training in the Eye Gaze Assessment by Dr. Lawrence and/or KSSB.
☐ **I DO NOT consent** to the use of videos or photos outside of my child's current educational team.

Child's Name: _____ **Date of Birth:** _____

Parent/Guardian Printed Name: _____ **Relationship:** _____

Signature: _____ **Date:** _____

Email address to share results: _____

For more information:
Anna Cyr, M. Ed, TSVI/COMS, KSSB Field Services Specialist
acyr@kssdb.org (913) 645-5324

KanLovKids Clinic Programs

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: _____