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# Quality Care for Kids – Vision & Hearing

EMINENCE INDEPENDENT

EMINENCE ELEMENTARY

☐ Male ☐ Female Age: _______ Grade: _______ Teacher: ___________________

Print Clearly

NAME:_______________________________________________ Date of Birth:______/______/______

FIRST MI LAST

**VISION** SYMPTOMS AND HISTORY

| Yes | No | ? | | Yes | No | ? | |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | Wears Glasses | ☐ | ☐ | ☐ | Blurred Vision |
| ☐ | ☐ | ☐ | Vision Loss | ☐ | ☐ | ☐ | Double Vision |
| ☐ | ☐ | ☐ | Eye Injury | ☐ | ☐ | ☐ | Gritty Sensation |
| ☐ | ☐ | ☐ | Head Injury | ☐ | ☐ | ☐ | Sensitive to Light |
| ☐ | ☐ | ☐ | Red Eyes | ☐ | ☐ | ☐ | Sits close to TV |
| ☐ | ☐ | ☐ | Dry Eyes | ☐ | ☐ | ☐ | Holds items close |
| ☐ | ☐ | ☐ | Watering Eyes | ☐ | ☐ | ☐ | Can't see the chalk board |
| ☐ | ☐ | ☐ | Blinks more than frequently | ☐ | ☐ | ☐ | Avoids close work |
| ☐ | ☐ | ☐ | Burning Eyes | ☐ | ☐ | ☐ | Sudden Vision Loss |
| ☐ | ☐ | ☐ | Encrusted Eyes or Lids | ☐ | ☐ | ☐ | Writes letters backwards |
| ☐ | ☐ | ☐ | Itching Eyes | ☐ | ☐ | ☐ | Leaves out words when reading |
| ☐ | ☐ | ☐ | Headaches | ☐ | ☐ | ☐ | Sees Spots |
| ☐ | ☐ | ☐ | Squints | ☐ | ☐ | ☐ | Sees Halos around light |
| ☐ | ☐ | ☐ | Eye Pain or Soreness | ☐ | ☐ | ☐ | Sees flashes of light |
| ☐ | ☐ | ☐ | Seasonal Allergies | ☐ | ☐ | ☐ | Loses place while reading |
| ☐ | ☐ | ☐ | Loss of Depth Perception | ☐ | ☐ | ☐ | Born Premature |
| ☐ | ☐ | ☐ | Loss of Color Vision | ☐ | ☐ | ☐ | Had Vision Therapy |
| ☐ | ☐ | ☐ | Bumps into objects with one side of the body | ☐ | ☐ | ☐ | Other ______________ |

Did we see your child LAST YEAR at school?
☐Yes ☐No

If yes, were the results normal ?
☐Yes ☐No

**Date of last Eye Exam :** __________________

Was an Rx written ☐Yes ☐No

Did "we" write it? ☐Yes ☐No

**Eye Dr.:** ________________________________

<u>Allergic</u> to any medications? ☐Yes ☐No

If so, what?

________________________________

<u>On a Prescribed</u> Medication now:

☐Yes ☐No If so, what and what for?

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**Check Child or Family for the following:**

| Child / Family | | Child / Family | |
|---|---|---|---|
| ____/____ | Lazy Eye | ____/____ | Blindness |
| ____/____ | Crossed Eye | ____/____ | Eye Disease |
| ____/____ | Glaucoma | ____/____ | Macular Degeneration |
| ____/____ | Diabetes | ____/____ | Retinitis Pigmentosa |
| ____/____ | Cataracts | ____/____ | Stroke |

1. Have Glasses now ? ☐Yes ☐No
2. Wear them regularly ? ☐Yes ☐No
3. Are they Lost ? ☐Yes ☐No
4. Are they Broken ? ☐Yes ☐No
5. Need another pair ? ☐Yes ☐No

**Student Address:** ________________________________________

**City:** __________________________ **Zip** _______________

**Phone:**____________________________________________

**Social Security No. :** _________________________________

Height___________Weight__________

➡ **PLEASE READ…**

Those with Insurance will receive a FULL exam.
Those without Insurance will receive a Screening.
Those that do not pass the Screening are provided a full exam.
Your insurance WILL be billed. You <u>will NOT</u> be billed for the balance.

**<u>CIRCLE INSURANCE BELOW</u>**

PASSPORT AETNA BETTER HEALTH WELLCARE HUMANA ANTHEM

______________________________________________________

Medicaid ID Managed Care ID

**OR** Commercial Insurance: BCBS United Health Care, Aetna, Tricare Bluegrass Family Health, Cigna, Humana, Anthem

______________________________________________________

Guarantor Name Guarantor DOB

Guarantor ID: _________________ Social:___________________

Do you have vision coverage? ☐Yes ☐No

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☐ Male ☐ Female Age: _______ Grade: _______ Teacher: ____________________

NAME:____________________________________________________ Date of Birth:_______/______/_______

FIRST MI LAST

**HEARING SYMPTOMS AND HISTORY**

| Yes | No | ? | | Yes | No | ? | |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | Ask to have things repeated | ☐ | ☐ | ☐ | Muffled speech |
| ☐ | ☐ | ☐ | Plays music too loud | ☐ | ☐ | ☐ | Difficulty understanding words |
| ☐ | ☐ | ☐ | Plays TV too loud | ☐ | ☐ | ☐ | Ask others to speak more loudly |
| ☐ | ☐ | ☐ | Not pay attention when called | ☐ | ☐ | ☐ | Ask others to speak more clearly |
| ☐ | ☐ | ☐ | Watches speakers lips | ☐ | ☐ | ☐ | Withdraws from conversations |
| ☐ | ☐ | ☐ | Has a lot of ear wax | ☐ | ☐ | ☐ | Has middle ear abnormality |
| ☐ | ☐ | ☐ | Has many ear infections | ☐ | ☐ | ☐ | Complains about loud noises |
| ☐ | ☐ | ☐ | Has Tubes in ears now | ☐ | ☐ | ☐ | Has cochlear implants |
| ☐ | ☐ | ☐ | Had tubes but not now | ☐ | ☐ | ☐ | Has ruptured eardrum |
| ☐ | ☐ | ☐ | Diagnosed with hearing loss | ☐ | ☐ | ☐ | Around loud noise all the time |
| ☐ | ☐ | ☐ | Failed a hearing test | ☐ | ☐ | ☐ | Shoots guns often |
| ☐ | ☐ | ☐ | Wears a hearing aid | ☐ | ☐ | ☐ | Has hereditary hearing problems |
| ☐ | ☐ | ☐ | Missing an ear | ☐ | ☐ | ☐ | Has speech therapy |
| ☐ | ☐ | ☐ | Earaches | ☐ | ☐ | ☐ | Born premature |
| ☐ | ☐ | ☐ | Has had a head trauma | ☐ | ☐ | ☐ | Does not respond to loud noise |
| ☐ | ☐ | ☐ | Has had ear surgery | ☐ | ☐ | ☐ | Ringing in the ears |
| ☐ | ☐ | ☐ | Lots of ear drainage | ☐ | ☐ | ☐ | Uses Q-Tips |
| ☐ | ☐ | ☐ | Experience dizziness | ☐ | ☐ | ☐ | Wear headphones a lot |

If you answered **YES** to any item or have another issue not listed, please explain in detail:

________________________________

**Date of last Hearing Exam :** ____________

Diagnosed with hearing loss ☐Yes ☐No

**Dr.**: ____________________________

Did we see your child last year at school for Hearing ? ☐Yes ☐No

If yes, were the results normal ? ☐Yes ☐No

**Check Child or Family for the following:**

| Child / Family | | Child / Family | |
|---|---|---|---|
| ____/____ | Deaf | ____/____ | Down syndrome |
| ____/____ | Hearing aids | ____/____ | Autistic |
| ____/____ | Diabetes | ____/____ | Otosclerosis |
| ____/____ | Seizures | ____/____ | Meningitis |

**PLEASE READ…**

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## VISION & HEARING Notes and concerns from Parent, Teacher, FRC or School Nurse:

I request and authorize Quality Care for Kids “QCFK” to perform a routine vision and hearing test on my child. I authorize my Commercial, Medicaid or other Insurance Benefits, be paid directly to QCFK. I authorize QCFK to provide a summary of findings to my child’s school, physician or specialist if a problem is identified. I authorize QCFK to dilate my child’s eye if necessary.

☐ **I DO NOT** give permission to dilate my child’s eyes

**Race**

____ American Indian ____ Native Hawaiian ____ White
____ Alaska Native ____ Asian ____ Black / African American

**Ethnicity**

____ Hispanic or Latino
____ Not Hispanic or Latino

☒ ________________________ ☒ ________________________ ☒ ____________

Parent or Guardian Signature — Printed Name of Parent or Guardian — Date



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