WesternU Health | Pomona
Eye Care Institute

795 E. Second Street, Suite 2
Pomona, CA 91766-2007
Tel: (909) 706-3899 • Fax: (909) 469-8640

Consent for Treatment of Minor Child

By completing this form, it will authorize an alternate decision maker to consent to, and be involved in, Medical treatment services and care of your minor child here at the Western University Eye Care Institute.

Minor Child's Name_____

Date of Birth _____ Age _____

I authorize Western University Eye Care Institute to provide the following treatments:

- Physical Examination
- Administer Immunizations
- Treat wounds
- Other _____

___ **Direct authorization for care/treatment.** I authorize Western University Eye Care Institute to provide the above named minor child with emergency, urgent and other Medical care and treatment in my absence.

___ **Designation of Parent Substitute to authorize care/treatment for minor child.** I authorize the Parent Substitute designated below to give informed consent for emergency, urgent and other Medical treatment for the Minor child.

___ **Identification of Parent Substitute.** I appoint the following individual(s) to obtain access to Protected Health information, give informed consent for Medical treatment, or otherwise receive custody of the Minor Patient.

_____

Name/Relationship Address

___ **Duration of authorization.** This consent is valid for one (1) year beginning on _____, 20____ and expiring on _____, 20 ____. This authorization may be revoked by me at any time prior to that expiration date by providing Western University Eye Care Institute with written notice.

___ **Release of Information.** To ensure that the Parent Substitute has access to Protected Health Information needed to make informed consent decisions, I authorize Western University Eye Care Institute to provide the above named Parent Substitute with Protected Health Information relating to the Minor child only. "Protected Health Information" means all Medical records relating to the Minor child which are protected and confidential as is defined by HIPAA/HITECH, and include: account information, appointments, and treatments planned or given. I also agree to release Western University Eye Care Institute and the providers from liability for any claims resulting from release of Protected Health Information in reliance upon this authorization.

I have carefully read and considered this consent for before signing it.

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

_____ _____
Signature (specify parent or guardian) Date

_____ _____
Signature of Witness Date

CONTACT INFORMATION For Parent or Legal Guardian:

Name:_____

Mailing Address:_____

Home Phone Number:_____ Cell Phone Number: _____

Work Phone Number: _____ Other Contact Information: _____

A signed electronic copy of this form is as valid as the original.

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Pediatric Ocular Case History Form

Name_____ DOB_____ Date_____

Mother's name_____ Father's name_____

Grade: _____Teacher's name: _____

Name and address of School: _____

Referred By_____

This is your opportunity to tell us about all areas of concern about your child's vision.

What is your main reason for coming here today? _____

_____

Date of child's last eye examination_____

Has your child ever worn glasses ❑ Yes ❑ No Does he/she wear them now? ❑ Yes ❑ No

If yes, does your child wear them: ❑ for distance only ❑ for near only ❑ wears them full time

Does your child wear contact lenses? ❑ Yes ❑ No Any problems? _____

Has your child ever received Optometric Vision Therapy? ❑ Yes ❑ No

Health History: Check any conditions that apply to your child or that run in your family.

Allergies	❑ Child	❑ Family	Lazy eye	❑ Child	❑ Family
Respiratory disease	❑ Child	❑ Family	Turned eye	❑ Child	❑Family
Cancer	❑ Child	❑ Family	Color deficiency	❑ Child	❑ Family
Diabetes	❑ Child	❑ Family	Light sensitive	❑ Child	❑ Family
Heart problems	❑ Child	❑ Family	Eyestrain	❑ Child	❑ Family
High blood pressure	❑ Child	❑ Family	Dry eyes	❑ Child	❑ Family
Thyroid disease	❑ Child	❑ Family	Floaters/spots	❑ Child	❑ Family
Migraine or headaches	❑ Child	❑ Family	Flashing lights	❑ Child	❑ Family
Blindness	❑ Child	❑ Family	Retinal detachment	❑ Child	❑ Family
Head trauma	❑ Child	❑ Family	Cataracts	❑ Child	❑ Family
Seizures	❑ Child	❑Family	Glaucoma	❑ Child	❑ Family
			Eye surgery or injury _____		

Is your child currently under a physician's care? ❑ Yes ❑ No Why?_____

Pediatrician's name _____ Date of child's last physical_____

What medications, if any, is your child taking and for what purpose?_____

_____

Does your child have any allergies to medications?_____

How is your child's general health?_____

Any past illnesses, bad falls or high fevers? ❑ Yes❑ No

What were they and when?_____

Does anyone in the family have a learning problem? ❑ Yes ❑ No If yes, whom?

Developmental Milestones

Full Term Pregnancy? ❑ Yes ❑ No Normal Birth? ❑ Yes ❑ No Birth weight_____

Any complications before, during or immediately following delivery? ❑ Yes ❑ No

Please describe_____

Did your child creep (stomach on floor)? □ Yes □ No at what age?_____
Did your child crawl (stomach off floor)? □ Yes □ No at what age?_____

At what age did your child walk? _____ Was/Is your child active? □ Yes □ No
Speech: First words at age_____ Was early speech clear to others? □ Yes □ No
Is child's speech clear now? □ Yes □ No
Has your child been diagnosed on the autism spectrum? □ Yes □ No
Has a neurologic evaluation been performed? □ Yes □ No
Has an OT/SPEECH/PT evaluation been performed? □ Yes □ No If Yes, by whom? _____
Recommendation given: _____

School-Related Vision Concerns: Questions for parents

Have any of your children had difficulty in school? ❑ **Yes** ❑ **No**
Please describe_____
Does your child like school? ❑ Yes ❑ No
Has any grade been repeated? ❑ Yes ❑ No If yes, which grade and why?_____
Does your child seem to be under tension when doing schoolwork? ❑ Yes ❑ No
Has your child had any tutoring, therapy or remedial assistance? ❑ Yes ❑ No When?_____
Where? _____ Given by? _____ For how long?_____
Which subjects are:
Above average_____ Average _____ Below Average_____
Do you feel your child is achieving up to potential? ❑ Yes ❑ No
Does the teacher feel your child is achieving up to potential? ❑ Yes ❑ No
Does your child have an IEP? ❑ Yes ❑No

Check the column which best represents how often each symptom occurs when reading.

	NEVER	Not Very Often-infrequent	SOMETIMES	Fairly often	ALWAYS
Score	0	1	2	3	4
1. Do your eyes feel tired when reading or doing close work?					
2. Do your eyes feel uncomfortable when reading or doing close work?					
3. Do you have headaches when reading or doing close work?					
4. Do you feel sleepy when reading or doing close work?					
5. Do you lose concentration when reading or doing close work?					
6. Do you have trouble remembering what you have read?					
7. Do you have double vision when reading or doing close work?					
8. Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?					
9. Do you feel that read slowly?					
10. Do your eyes ever hurt when reading or doing close work?					
11. Do your eyes ever feel sore when reading or doing close work?					
12. Do you feel a “pulling” feeling around your eyes					
13. Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14. Do you lose your place while reading or doing close work?					
15. Do you have to re-read the same line of words when reading?					
Totals					

How does your child react to fatigue? ❑ Drags ❑ Becomes Irritable ❑ Becomes Excited
Other Reaction_____

How does your child react to tension? ❑ Turn inward ❑ Nail biting (anxiety) ❑Anger
Other Reaction_____

Does your child have any behavior problems at school? _____

Does your child have any behavior problems at home? _____

Is your child in constant motion? ❑Yes ❑ No Can your child sit for long periods? ❑ Yes ❑ No

Does your child like to read? ❑ Yes ❑ No Does your child voluntarily read for pleasure? ❑ Yes ❑ No

Recreation and Leisure

In what recreational activities does your child participate?

❑Read ❑Baseball ❑ Basketball ❑ Soccer ❑ Swims ❑ Build models ❑ Sew ❑Dance
❑ Perform ❑ Plays a musical instrument

Other recreational or sports activities? _____

Does your child wear protective eyewear for his/her sport? ❑**Yes** ❑**No**
Does your child watch much television? ❑ **Yes** ❑ **No** Number of hours daily_____
Does your child use a computer at home? ❑ **Yes** ❑ **No** Number of hours daily_____
Does your child use a computer at school? ❑ **Yes** ❑ **No** Number of hours daily_____
Does child often play video games? ❑ **Yes** ❑ **No** Number of hours daily_____
Does he/she play hand-held video games? ❑ **Yes** ❑ **No** Screen type ❑ Bright ❑ Dim

Family and Home

Which adults does your child live with?
□ Mother □ Father □Stepmother □Stepfather □Foster parents
□ Adoptive Mother □ Adoptive Father □Grandmother □Grandfather □Aunt □Uncle
□Other _____

Names and ages of children your child lives with _____
_____
_____

Has your child been through a traumatic family situation?
□ Divorce □Separation □Parental Loss □Parental Illness □Other

Is family life stable for your child at this time? □Yes □No

Give a description of your child as a person: _____
_____
_____

Name of Person Completing this Form: _____

Signature_____ Date _____