

June, 2007

## **Healthy Eyes Are the Key to Successful Learning in All Children**

**Assuring a child's ability to see clearly in school is one of the most effective ways to maximize their learning potential. With 80% of all learning in children obtained through vision, it is imperative that School Administrators like you are aware of the all the facts and resources available to help your students.**

In 2001, the Wisconsin Optometric Association (WOA), a professional association of doctors of optometry, worked with lawmakers to pass one of the first children's vision laws in the nation. Wisconsin's law requires all Public School Districts in the state to encourage children entering Kindergarten to have their eyes tested before entering school. Given the fact good vision and eye health is important to all children, not just Kindergartners, the WOA is asking you to provide the enclosed information to all the grade levels in your school district.

### **A Pledge to All Wisconsin Students:**

In 2001, WOA members made a public pledge to ALL students in the state that they will provide vision and eye health care to any child who needs care and can't afford it. We do this by offering several benevolent (free of charge) program designed for those children who do not qualify for medical assistance or do not have private insurance. One of these programs is called Vision USA. This program offers children of low income working families free vision and eye health exams and glasses.

Our work is far from over. Thousands of students attend classes each day with vision and/or eye health problems. These children struggle to see the board, read a book or work on the computer. We should all take responsibility for these children!

### **How Can You Help?**

The WOA's children's vision efforts need broad support. Specifically, we need you to continue spreading the message about good vision and successful learning to the key players in your district. We ask that you forward this information packet to your district's principals, teachers and school nurses.

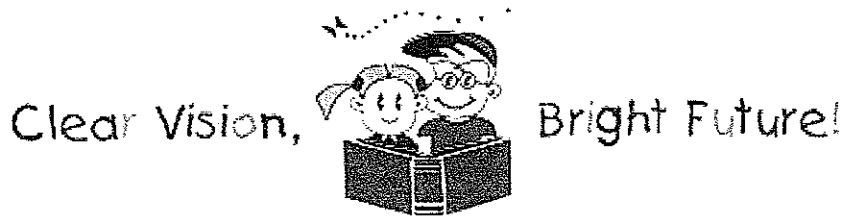
Enclosed you will find the following information:

- Teachers guide to student vision in the classroom
- Announcement of 4th annual "Clear Vision, Bright Future" Poster Contest (grades K-5)
- VISION USA program application to provide free eye care and glasses to needy children
- Copy of Wisconsin's Children's Vision Law and DPI Exam Form
- General Eye examination form for grades 1-12

As a school district administrator, you play a vital role in the quality of your students learning experience. By helping the WOA spread the message regarding vision and eye health, you are ensuring that your students maximize their academic performance.

Warmest regards,

Dr. Michelle Harper  
WOA President



## VISION USA – The Wisconsin Project Patient Application Form

VISION USA – The Wisconsin Project offers comprehensive eye care services to children age 18 and under from low-income working families whose children have no eye care health insurance. Applications will be accepted year-round and if approved, the applicant will be sent information on contacting a local doctor to set up an eye exam. It is the parent/guardian's responsibility to contact the doctor and make the appointment. Each eligible child will receive a free comprehensive eye examination. Whenever possible, the Wisconsin Optometric Association will work with local eye doctors and service organizations such as the Lions Club to provide basic lenses if prescribed. **Note: Volunteer doctors provide these services and a participating doctor may or may not be available in your area.**

Eligibility requirements are as follows. Please read them carefully to make sure you qualify.

1. Parent or guardian of child must be currently working at least part-time.
2. Patient must be age 18 or under.
3. Patient must have **NO** eye health insurance (including Medicaid, Blue Cross/Blue Shield, Badger Care). If they do have insurance that covers eye care, they will be denied a VISION USA exam.
4. Patient must not have had an eye exam by an optometrist within the last 12 months.
5. Family income must be below an established level according to household size.  
\*\*Parent or guardian must enclose, with completed application, a copy of most recent tax return, or verification from school stating that the child qualifies for free/reduced lunch. All applications must be returned without a form of income verification.

\*\*The applicant must meet ALL of the first four requirements, regardless of income level. If they do not meet these four requirements, they will NOT qualify for the program.

More than one person in each family may apply for an exam, if eligibility requirements are met. Please submit one application per child. For more information, or to obtain an application in Spanish, call 1/877-435-2020, or visit [www.woa-eyes.org](http://www.woa-eyes.org).

Send this completed form with requested information to:

VISION USA – The Wisconsin Project  
6510 Grand Teton Plaza Suite 312  
Madison, WI 53719

## VISION USA – The Wisconsin Project Patient Application Form

VISION USA – The Wisconsin Project provides free eye exams to eligible children age 18 and under from low-income working families who have no eye health insurance. Services are donated by volunteer optometrists and may be limited in some areas. Eligibility requirements must be met to qualify.

You must answer **ALL** information and questions. Complete one form for each child applying. **PLEASE PRINT LEGIBLY.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone Number: (    ) \_\_\_\_\_

Applicant Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Gender: (circle one) Male      Female Date Applicant will/did enter kindergarten: \_\_\_\_\_

### Please answer all questions below.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Is a parent or guardian of above child currently working at least part-time?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is applicant age 18 or under?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the applicant have eye care coverage by any type of government or private health care insurance (Medicaid, Medicare, Blue Cross/Blue Shield, Badger Care) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the child who is applying had an eye examination at an <u>eye doctor's</u> office within the past 12 months?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. What is the total number of people living in your household including applicant? _____   |                          |                          |
| 6. What was your household's adjusted gross income last year? ** _____ **   |                          |                          |
| 7. Who referred you to this program? _____  |                          |                          |

**\*\*Please include a copy of your most recent federal tax return, or school verification of free/reduced lunch. Income verification must be included in order for application to be processed.**

Your completed application form will be reviewed to determine your eligibility. If you qualify, you will receive a letter with information on contacting a participating doctor in your area. If you do not qualify, you will be notified in writing within 2-4 weeks of receipt of your application.

Please return completed application to:  
VISION USA – The Wisconsin Project, 6510 Grand Teton Plz Ste 312, Madison, WI 53719

State of Wisconsin  
Department of Regulation and Licensing

**KINDERGARTEN EYE HEALTH EXAMINATION REPORT**

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_  
Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ County \_\_\_\_\_  
School/Kindergarten \_\_\_\_\_ City \_\_\_\_\_  
Date entering Kindergarten \_\_\_\_\_

The State of Wisconsin encourages parents of Kindergartners to arrange for their child's eyes to be examined by an optometrist or evaluated by a physician by December 31 of the child's first year in school. An examination or evaluation should include, at a minimum, the elements listed below. (By checking the box, the examining doctor is indicating that the element checked was performed.)

- Brief history (general health and eye health) of the child, including family history
- General external observation of the child's eyes and surrounding structures
- Ophthalmoscopic examination through an undilated pupil
- Gross measurement of peripheral vision
- Evaluation of eye coordination and function (alignment and motility)
- Visual acuity for each eye (separately)

Findings:

As a result of this examination, follow-up care for the child is recommended:     Yes     No

Date of examination:  
\_\_\_\_\_

Doctor/Physician Signature:  
\_\_\_\_\_

Print or stamp:  
Doctor/Physician Name  
Address  
Phone

**IMPORTANT NOTICE TO PARENTS**

**This examination is not required by law.** Disclosure of the information noted above is necessary to comply with the statutory purpose as outlined in s. 118.135, Wis. Stats.

Disclosure of this information is voluntary and there is no penalty for non-compliance.

You are encouraged to provide a copy of this form to the school and keep a copy for your record.

**Consent of parent or guardian:** I agree to release the above information on my child to appropriate school authorities and consent to my child obtaining an eye examination.

Signature \_\_\_\_\_  
Date \_\_\_\_\_

# Student Vision and Eye Health Examination Form

Because 80% of all learning in children is obtained through vision, it is imperative that your child receive the proper vision and eye health care you can give them. As many as 25% of all children have vision problems significant enough to prevent them from succeeding in school. Moreover, most children don't know they have a vision problem. As adults, we must act on their behalf. **If your child has not had a complete eye examination by an eye care professional in the last 12-24 months, please make an appointment for them today and give them every opportunity to excel in the classroom.**

Date of Exam: \_\_\_\_\_ Student's Name: \_\_\_\_\_

Please complete the following information. *Thank You*

### UNCORRECTED

DISTANCE	NEAR
Visual Acuities	Visual Acuities
RIGHT 20/	RIGHT 20/
LEFT 20/	LEFT 20/

### CORRECTED

DISTANCE	NEAR
Visual Acuities	Visual Acuities
RIGHT 20/	RIGHT 20/
LEFT 20/	LEFT 20/

COLOR VISION    \_\_\_\_\_ / 6 OD    \_\_\_\_\_ / 6 OS    STEREO    \_\_\_\_\_ / 9

**VISUAL ABILITIES:**

- |                                 |                                    |                                     |
|---------------------------------|------------------------------------|-------------------------------------|
| Eye Teaming                     | <input type="checkbox"/> Normal    | <input type="checkbox"/> Imbalanced |
| Convergence Ability             | <input type="checkbox"/> Excellent | <input type="checkbox"/> Adequate   |
| Focusing Ability                | <input type="checkbox"/> Excellent | <input type="checkbox"/> Adequate   |
| Stereopsis (3-D Vision Ability) | <input type="checkbox"/> Excellent | <input type="checkbox"/> Adequate   |

**EYE HEALTH STATUS:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Eye Health Status is Normal | <b>Monitor Risk of:</b><br><input type="checkbox"/> Cataract<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Macular Degeneration<br><input type="checkbox"/> Diabetic/Hypertensive Retinal Disease<br><input type="checkbox"/> Retinal Hole/Detachment | <b>Diagnosed:</b><br><input type="checkbox"/> Cataract<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Macular Degeneration<br><input type="checkbox"/> Diabetic/Hypertensive Retinal<br><input type="checkbox"/> Retinal Hole/Detachment |
|--|--|--|

**GENERAL EYE HEALTH:** \_\_\_\_\_

Does this child need to wear glasses: \_\_\_\_\_ YES \_\_\_\_\_ NO  
 If so, when: \_\_\_\_\_ Constantly \_\_\_\_\_ Reading Only \_\_\_\_\_ Distance Only

RECOMMENDED DATE FOR NEXT EXAM: \_\_\_\_\_

Examining Eye Doctor's Name: \_\_\_\_\_

Examining Eye Doctor's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Please return this form to:  
  
(Insert your school address here)

**Consent of parent or guardian:**  
 I agree to release the above information on my child to appropriate school authorities and consent to my child obtaining an eye examination.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_