The Smokey Powell Center

OFFICE OF State Schools

Dual Referral Checklist for: **Eye Health Clinic (EHC)** and **Low Vision Clinic (LVC)**

Student Name: _____ DOB (m/d/yyyy): _____

Georgia Testing ID (10 digit): _____ School District: _____

Prior Low Vision Evaluation?: ____ Yes ___ No Location of Evaluation: _____

Date of latest Eye Report on file: _____

TVI Name: _____ Email: _____ Phone: _____

SpEd Dir. Name: _____ Email: _____

The following is our **Eye Health Exam** and **Low Vision Evaluation** list of items needed to complete the dual referral packet. Please make sure the packet is complete before submitting it.

The packet will be returned if <u>any</u> items are missing or are out of date.

1. ____ Both the Student and TVI are registered with the GIMC*
2. ____ Request for Evaluation (signed by the SpEd Dir. on district letterhead)
3. ____ Parental Consent for Evaluation (your district form)
4. ____ Current Eye Report **OR** _____ Scheduling EHC w/ SPC
5. ____ Current Individualized Education Plan (IEP)
6. ____ Functional Vision/Learning Media Assessment
7. ____ Authorization to Release Information Form (Page 2)
8. ____ Eye Health Clinic Participation Form (Page 3)
9. ____ Photo Release -*If parent/guardian will not be in attendance* (Page 4)
10. ____ Vision teacher or LSS designee will attend

* To register with the Georgia Instructional Materials Center please go to <u>www.gimc.org</u>. If you and the student are already registered with the GIMC, please log in and edit (update) your student's information.

You will be contacted for scheduling when we receive and review the completed packet.
We look forward to working with you and your student. Parents are welcome and encouraged to attend eye health exams and low vision evaluations. Please do not hesitate to contact us if you have any questions or concerns.

Sincerely,

Heather Francis, Admin. Assistant hfrancis@doe.k12.ga.us

Smokey Powell Center
2895 Vineville Avenue Macon, GA 31204
Phone: 478-751-6083 x3624 Fax: 866-237-5968

Richard Woods, Georgia's School Superintendent
"Educating Georgia's Future"

Leslie Jackson, Director of State Schools

The Smokey Powell Center

AUTHORIZATION TO RELEASE INFORMATION

I hereby permit the Smokey Powell Center to release school records on:

(Name of Student)

To: The Smokey Powell Center Low Vision Optometrist

Reason for Request: Low Vision Evaluation

Records Requested: Eye Report, Functional Vision Assessment, Other reports related to vision

This information may not be transferred to any third parties nor may they have access to the information without the written consent of the parent or eligible student.

I hereby release the administration and the staff of the above agency/institution issuing the information from all liability and all claims of any nature whatsoever pertaining to disclosure of this information.

_____

Signature

_____

Relationship

_____

Date

EYE HEALTH CLINIC PARTICIPATION FORM

The Smokey Powell Center is a program operated by the Georgia Department of Education-Office of State Schools that enhances vision services for children who are blind or visually impaired. The Center provides clinical low vision evaluations, eye health examinations, and access technology (AT) assessments throughout the state. Our primary goal is to ensure that students who are blind or visually impaired have appropriate access to essential eye care and vision services.

The eye health clinic may involve the dilation of the eyes. We also offer information and education about vision services to families. If necessary, referrals to other providers may be made. There are no costs for families for their child's participation at the Smokey Powell Center.

Your child's privacy is of utmost importance to us. The Smokey Powell Center team adheres to strict regulations to maintain the confidentiality of your child's information. However, with data collection, there is always some risk involved. Information regarding you and your child will be kept private to the extent permitted by law. All data will be stored in password-protected files on firewall-secured computers. Testing results may be shared with local school systems. To support your child's needs during the eye health clinic exam, a copy of their most recent eye report and Individual Education Plan (IEP), if applicable, will be provided to the Smokey Powell Center by the local school system.

Does your child have any allergies?

- ☐ Yes
- ☐ No
- ☐ If yes, please list here: _____

For any questions regarding the Smokey Powell Center, please contact Zel Murray, Program Manager, Division of State Schools, Georgia Department of Education, or email zmurray@doe.k12.ga.us.

PARENT/GUARDIAN PERMISSION FOR CHILD

I have read and understand the contents of this permission form and have been given the opportunity to ask questions and receive answers. I give my permission for my child to participate in the Smokey Powell Center Eye Health Clinic. I understand that a copy of my child's IEP will be shared with the Smokey Powell Center.

_____Name of Child (Please print)

_____Name of Parent/Guardian (Please print)

_____Signature of Parent/Guardian

_____Date

Smokey Powell Center

OFFICE OF State Schools

Permission to Use Photograph

Event:

- ○ Eye Health Clinic/Exam
- ○ Clinical Low Vision Evaluation
- ○ Access to Technology (AT) Assessment/Consult

Location:

- ○ Smokey Powell Center
- ○ Satellite Clinic
- ○ Virtual

- ○ I grant to allow the Smokey Powell Center the right to take photographs of my child in connection with the above-identified event. I authorize the Smokey Powell Center, its assigns and transferee's to copyright, use and publish the same in print and/or electronically.

- ○ I agree that the Smokey Powell Center may use such photographs of my child with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

- ○ I have read and understand the above:

Child's Name _____

Parent's Name _____ Date _____

Signature, Parent or Guardian _____

(If under age 18)