The Smokey Powell Center

OFFICE OF State Schools

Referral Checklist for: **Eye Health Clinic (EHC)**

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

School District_____ Date of latest Eye Report on file: _____

TVI Name: _____ Email: _____ Phone: _____

SpEd Dir. Name: _____ Email: _____

The following is our **Eye Health Clinic** list of items needed to complete the referral packet. Please make sure the packet is complete before submitting it.

1. **Reason for Eye Health Exam Only (check all that apply):**
   ☐ Student does not have sufficient functional vision for a Low Vision Evaluation (LVE)
   ☐ Student has a recent LVE on file (please attach)
   ☐ Student's FVLMA serves in place of an LVE due to the complexity of needs
   ☐ Other: _____
2. ☐ **Authorization to Release Information Form**
3. ☐ **Eye Health Clinic Participation Form**
4. ☐ **Most Current Eye Report on File**
   (Include all relevant medical/eye care reports)
5. ☐ **IEP and/or Functional Vision/Learning Media Assessment**
   (Not required, but helpful)
6. ☐ **Photo Release Form**
   (Required if parent/guardian will not be in attendance)
7. **TVI or Designee Attendance**
   ☐TVI or designee will attend the clinic virtually
   ☐ TVI or designee will attend the clinic in person

You will be contacted to 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. 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

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 Tara Bowie, Program Manager, Division of State Schools, Georgia Department of Education, or email Tara.Bowie@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

Parent Email:_____Date_____

Smokey Powell Center

OFFICE OF State Schools

Permission to Use Photograph

Event:

- ○ Eye Health Clinic
- ○ Clinical Low Vision Evaluation
- ○ AT Assessment

Location:

- ○ Smokey Powell Center
- ○ 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)

Email: _____