

SOUTH PEKIN GRADE SCHOOL DISTRICT 137
206 West Main St., P O Box 430
South Pekin, IL 61564-0430
Phone 309-348-3695 / Fax 309-348-3162

NOTIFICATION OF VISION AND HEARING SCREENING

410 ILCS 205/Child vision and Hearing Test Act requires that children in specified age groups receive vision and hearing screening. Public Act 093-0504 requires that a child's parent or guardian be notified in writing before vision screening is done. "Vision screening is not a substitute for a complete eye and vision examination by an eye doctor. Your child is not required to undergo this vision screening if an optometrist or ophthalmologist has completed and signed a report form indicating that an examination has been administered within the previous 12 months AND the evaluation is on file with the school."

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE Tazewell County Health Department to release health information on my child:

_____ Date Of Birth ____/____/____ In Grade _____
(PRINTED NAME OF CHILD)

To: South Pekin Grade School, 206 W. Main Street, Box 430, South Pekin, IL 61564

The following information shall be released (mark all applicable)

- Laboratory Reports
- Immunization Records
- Hearing and Vision Screening Records
- Other: _____

The purpose of the authorization is:

- At the Request of the Individual or Personal Representative
- Other: _____

This authorization is effective as long as the child is enrolled in the school named above.

I understand that I have the right to revoke this authorization by giving written notice to Tazewell County Health Department. I understand that I cannot revoke authorization for information already released in reliance on an Authorization that I have signed. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law.

I understand that the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I acknowledge that I have been offered Tazewell County Health Department's Notice of Privacy Practices.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date: _____

SIGNED AS: Parent Guardian Other: _____

Witness: _____