COBB COUNTY SCHOOL DISTRICT

Mass Screening Program
VISION
2018-19

Supervisor:
Dr. Bobbie Ealy
770-426-3497
Bobbie.Ealy@cobbk12.org

Education Program Specialists:
LeAnn Barnes
LeAnn.Barnes@cobbk12.org

Lakisha Stanley
Lakisha.Stanley@cobbk12.org
# TABLE OF CONTENTS

PROGRAM OVERVIEW ................................................................. 3

EYE CHART SCREENING: HOTV AND LEA SYMBOLS ....................... 5

VISION SCREENING ROSTER ......................................................... 7

FOLLOW-UP SCREENING PROCEDURES ........................................ 8
  FORM V-1: VISION SCREENING REFERRAL LETTER ................. 9
  FORM VS-1: VISION SCREENING REFERRAL LETTER - SPANISH 10
  FORM V-2: FOLLOW-UP VISION SCREENING LETTER ............. 11
  FORM VS-2: FOLLOW-UP VISION SCREENING LETTER – SPANISH 12
  FORM V-3: PARENT PERMISSION LETTER ............................. 13
  FORM VS-3: PARENT PERMISSION LETTER - SPANISH ........... 14
  REPORTING FORM FOR TOTALS –A200 ................................ 15

OPTOMETRIST CONTACT INFORMATION .................................... 16

EYE EXAMINATION RESOURCE GUIDE ....................................... 17

Special Education and Vision-Information for Teachers ............... 18

STATE OF GEORGIA EYE REPORT FORM .................................... 24
VISION - MASS SCREENING PROGRAM

PURPOSE: To detect those students who may have a vision disorder and refer them for further care.

STUDENTS TO BE SCREENED:
• MASS SCREENING GRADES: Parental Permission IS NOT Required for:
  A. Students in Grades 1, 4, 7, and 10
  B. All NEW STUDENTS to Cobb County School District who enter at any point during the year.

Some schools prefer to screen all students every year. If you choose to do this, please screen the grades listed above first. If your practice is to perform mass screening with all students, parental permission is not required for mass screenings.

• REFERRAL STUDENTS – Parent Permission (see forms) IS Required for:

Students who are not included in the mass screening grade levels (see above) and those who are referred by a teacher, parent or other staff person.

These students should be screened only after permission is received from the child's parents.

Permission forms signed by the parents may be placed in your mailbox throughout the year for referrals from teachers. Any child who is referred must receive a hearing screening within one month of the referral.

SPECIAL NOTE: The State of Georgia Health Department, in collaboration with the Department of Education has created new guidelines for school vision screening for the State and all local school districts. The new recommendations include the preferred use of the HOTV 10-foot screening chart for grades K-12.

The Vision Screening Program is not a substitute for routine vision care. It is recommended that all children receive a thorough eye exam by an optometrist or ophthalmologist before beginning Kindergarten. Annual eye exams are recommended for children who wear glasses or contacts. Children who do not wear corrective eye wear should have an eye exam every other year.
SCREENING PROCEDURES:

1. Screen students with either the 10-foot HOTV chart or the SPOT Vision Screener.
   (NOTE: If your school staff are trained by and/or supported by a local Lions Club, the use of the SPOT Vision Screener can be considered an acceptable alternative to HOTV).

2. Students who fail the initial screening are re-screened within two weeks (unless screened using the SPOT Vision Screener).

3. Parents of students failing the second screening are mailed a notification letter (V-1).
   a. Parents may take their child for an exam to a doctor of their choice, an optometrist or ophthalmologist *or*
   b. Parents may take their child (at no charge) for a refractive screening with:

      Dr. Ivo Horak, OD  
      CCSD Vision Consultant  
      Eyes R Us  
      735 Windy Hill Road Smyrna, GA 30080  
      (770) 436-9123

      Dr. Barry Schirack, OD  
      ProCare Eye Center  
      6572 Hwy. 92 Ste. 100  
      Acworth, GA 30102  
      (770) 924-3355

      Dr. Janelle Davison, OD  
      Brilliant Eyes Vision Center  
      1690 Powder Springs Rd., Ste. 101  
      Marietta, GA 30064  
      (770) 428-0414

      Dr. Dean Mobley, OD  
      Mobley Eye Care  
      2345 East West Connector  
      Suite 1010  
      Austell, GA 30106  
      (770) 941-2323

   The optometrist will advise parents whether or not their child needs a complete eye exam. Cobb County School District will cover the cost of the re-screening, but does not pay for full eye exams, medical treatment, or prescription eyewear.

   These doctors are also available to provide a full eye exam, if the parent so chooses; or parents may schedule an appointment with another eye health provider of their choice. The parent will be responsible for payment, if they choose to schedule a full eye exam for their child, regardless of the eye doctor chosen.

   This service is not available to charter school students.
EYE CHART SCREENING:
HOTV CHARTS

Testing Capabilities: Screens for distance vision problems.

Testing Limitations: Does not address reading / near-vision problems.

Staff Requirements: Two people (one pointer and one occluder/recorder).

HOTV CHART SCREENING

Equipment Requirements
1. HOTV 10-foot chart
2. 3x5 Index cards (occluder–trimming corners off is recommended)
3. Roster Form (V-4)
4. Masking Tape
5. Measuring Tape 10’
6. Pointer or Pencil
7. Cover Sheet
8. Paper Clips
9. Two paper Foot Prints (optional)

NOTE: LEA SYMBOLS CHARTS may be used with preschool or hard-to-test students.

HOTV Testing Guidelines

A. Preparation for the screening:
   a. Hang the HOTV chart at the average eye level of the age group being screened. The HOTV chart is appropriate for school-aged students.
   b. Screen using the: 20/40 line for KG and 1st Graders; and the 20/30 line for grades 2 thru 12.
   c. You may use paper clips and heavy paper to cover the lines not being tested.
   d. Place a line of tape or the heel of the paper footprints at a distance of 10 feet from the chart.
   e. For all students, make sure that they are able to identify the four letters: H, O, T, and V. (ie: Does the student know the names of those four letters?) You may use the top line on the chart to make this determination. If the child is not able to name the letters, you may use response cards (matching) or use an LEA Symbols chart.

B. Responsibilities of the screeners (pointers and occluder/recorders):
   a. One staff member should stand next to the chart and point to the symbol or letter that the student should identify.
b. One staff member should verify the symbol/letter is identified correctly and record a pass or fail response.

C. Initial screening procedures:
   a. The student’s heels are placed on the 10 foot line.
   b. Both eyes should be open at all times.
   c. If glasses or contact lenses are used to see at a distance then they should be worn during the screening.
      i. If the student fails the screening with the glasses on, then the glasses should be removed and the eyes should be retested.
      ii. If the student correctly identifies the symbols/letters without the glasses on then the glasses may be for reading.
   d. Use the occluder/index card to cover the eye not being tested. (It’s best practice to trim the cards/round the corners of the cards, to avoid having sharp corners near students’ eyes.)
   e. Never press on the eye with the index card as this may distort the vision.
   f. The right eye should always be tested first and then the left eye second.
   g. Point to the letters on the line being tested in random order.
   h. **To receive credit for a line, the child must correctly identify 3 of the 5 letters on the line.**
      i. Record the results of the screening as pass or fail for the right and then the left eye.
         i. 90% of the students should pass the screening.
         ii. Nearsightedness can tend to begin around age 9 (fourth grade), therefore you may have a slightly higher failure rate at that age.
   j. If a student’s eye turns up, down, in or out, then they fail the screening.

Record the results of the screening as pass or fail for the right and then the left eye.
## Vision Screening Roster

**School:** ____________  **Homeroom:** ____________  **Examiner:** ____________  **HOTV:** ___  **SPOT:** ___

<table>
<thead>
<tr>
<th>NAME</th>
<th>INITIAL TEST</th>
<th>RETEST</th>
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<td>DATE</td>
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</table>
FOLLOW-UP SCREENING PROCEDURES

A. Any student who fails the initial screening should be re-screened, using the identical screening procedure, within 2 weeks (unless screened with the SPOT Vision Screenr)
   a. Any student who fails the second screening will have a parent notification letter (V-1) mailed to their parent or guardian.
   b. The screening recording form (V-4) and a copy of the parent notification letter (V-1) must be kept on file in the school office for one year.

B. Screening authorizations:
   a. Parent permission for students screened in the mass screenings (grades 1, 4, 7 and 10) is not required.
   b. Parent permission is required for students not falling into a category listed in “a”, above.
   c. If a student is requested to be screened by a teacher, the school or a parent then a permission form (V-3) must be completed.
      i. The referring individual must complete form (V-3) and have it signed by the parent or guardian.
      ii. A student who is referred must be screened within one month of the referral.

C. Record keeping:
   a. If the response to the parent notification letter (V-1) is not received within 30 days, mail out the parent notification follow-up letter (V-2).
   b. All students new to Cobb County Schools must have a completed Certificate of Ear, Eye, Dental and Nutrition Examination (Form 3300) on file in the school office, dated no earlier than July 31, 2017.
      You are not required to complete a certificate for each student being screened.
   c. If a student chooses to see one of the eye doctors listed above (page 4), the eye doctor will notify the school via letter (CCS-3/5), regarding the results.
      i. Upon receipt of the letter (CCS-3/5), a note should be made on the list of the screening failures that the student has had a vision screening or exam performed by the vision consultant.

D. Confidentiality: Do not discuss the results of the screening with anyone other than the student, parents/guardians of the student, school officials or the student’s teachers.
Dear Parents:

This letter is to inform you about the VISION SCREENING PROGRAM conducted for our students. The school screening is not a substitute for a complete vision examination, but rather a way to identify students with a visual problem who are in need of further care. Your child was not able to pass the mass vision screening conducted at school. Failing the screening does not necessarily indicate that a problem exists, only that your child was not able to pass this particular screening. **We recommend that your child receive a complete vision examination by an eye doctor. Please take this form with you to your eye doctor when you have your child’s eyes examined.**

If you wish to verify the need for an eye examination, the district will provide a professional **re-screening** to you at no charge. This is a more thorough screening, performed by an eye doctor, but is not a full eye exam.

To schedule a professional **screening**, you may contact:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Ivo Horak, OD</td>
<td>Eyes R Us Family Optical, 735 Windy Hill Road, Smyrna, GA 30080 (770) 436-9123</td>
<td></td>
</tr>
<tr>
<td>Dr. Janelle Davison, OD</td>
<td>Brilliant Eyes Vision Center 1690 Powder4 Springs Rd., Ste. 101 Marietta, GA 30064 (770) 428-0414</td>
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<td>Dr. Barry Schirack, OD</td>
<td>ProCare Eye Center 6572 Hwy. 92 Ste. 100 Acworth, GA 30102 (770) 924-3355</td>
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<td>Dr. Dean Mobley, OD</td>
<td>Mobley Eye Care 2345 East West Connector Suite 1010 Austell, GA 30106 (770) 941-2323</td>
<td></td>
</tr>
</tbody>
</table>

Please let the secretary at the eye doctor’s office know that you would like to schedule a “Cobb County School Screening”. This is not a complete eye examination – It is re-screening to determine if a complete eye exam is needed.

If a complete eye examination is recommended, you may schedule a time to have your child seen by either Dr. Horak, Dr. Davison, Dr. Schirack, or Dr. Mobley - or any eye doctor of your choice. The cost of the full eye examination, treatments, or recommendations is the responsibility of the parents. If you have health insurance, you may wish to check with your plan to see if they cover the cost of an eye exam and/or prescription eyewear.

A child should have an eye exam before kindergarten. If a child wears glasses or contacts an eye exam is recommended each year. A child without prescription eyewear should have an eye exam every other year. **The eye doctor will be able to see additional family members, by appointment.**

Thank you very much.

---

**Student was tested with eye chart**

[ ] HOTV Chart  [ ] LEA Symbols Chart

<table>
<thead>
<tr>
<th></th>
<th>Right Eye</th>
<th>Left Eye</th>
<th></th>
<th>Right Eye</th>
<th>Left Eye</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Vision</td>
<td>[ ] Pass</td>
<td>[ ] Fail</td>
<td>Distance Vision</td>
<td>[ ] Pass</td>
<td>[ ] Fail</td>
</tr>
</tbody>
</table>

[ ] Student was tested with SPOT vision screener.

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**AFTER EYE DOCTOR APPOINTMENT: FINAL SCREENING RESULTS:**

**PARENTS: PLEASE DETACH THIS FORM AND RETURN IT TO YOUR CHILD’S TEACHER OR THE SCHOOL SECRETARY.**

- My child had a re-screening with Dr. __________________ on the following date: __________________________.
- My child had an eye examination on the following date: __________________________.
  - Prescription glasses or contacts were recommended.
  - No glasses or contacts were recommended.

**CHILD’S NAME: ________________________________**
**PARENT’S NAME: ______________________________**
**HOME PHONE NUMBER: ______________________________**
**WORK/CELL NUMBER: ______________________________**
Apreciados Padres de Familia:

Esta carta es para informarle acerca del PROGRAMA DE CHEQUEO DE LA VISTA para nuestros estudiantes. La prueba realizada en la escuela no remplaza el examen completo de la visión, pero sirve para identificar a los estudiantes que puedan tener problemas visuales y que necesitan de cuidado. Su hijo/a no paso la prueba de visión realizada en la escuela. El no haber pasado la prueba, no significa necesariamente que haya un problema de visión, solo que su hijo/a no paso este examen en particular. **Le recomendamos llevar a su hijo/a a una evaluación completa de la visión, por parte de un doctor especializado en visión. Por favor entreguele este formulario al doctor, el día de la cita.**

Si usted desea verificar la necesidad de un examen visual, el distrito le ofrece una evaluación refractiva, sin ningún costo. Esta es una evaluación más minuciosa, realizada por un Optómetro, pero no es un examen completo.

Para programar una cita de evaluación, comuníquese con:

Dr. Ivo Horak, OD  
Eyes R Us Family Optical,  
735 Windy Hill Road,  
Smyrna, GA  30080  
(770) 436-9123

Dr. Janelle Davison, OD  
Brilliant Eyes Vision Center  
1690 Powder4 Springs Rd., Ste. 101  
Marietta, GA  30064  
(770) 428-0414

Dr. Barry Schirack, OD  
ProCare Eye Center  
6572 Hwy. 92 Ste. 100  
Acworth, GA  30010  
(770) 924-3355

Dr. Dean Mobley, OD  
Mobley Eye Care  
2345 East West Connector  
Suite 1010  
Austell, GA 30106  
(770) 941-2323

Por favor dígale a la secretaria de la oficina del doctor, que usted quiere programar una "cita de evaluación de Cobb County School". Este no es un examen completo de la visión, es más una reevaluación para determinar si se necesita un examen completo.

Si le recomiendan un examen completo de la visión, usted debe programar una cita para que su hijo/a sea visto por Dr. Horak, Dr. Davison, Dr. Schirack o Dr. Mobley – o cualquier doctor que usted escoja. El costo del examen completo de la visión, de los tratamientos o de las recomendaciones, es responsabilidad de los padres. Si tiene un seguro de salud, debe chequear su plan para ver si cubre el costo del examen y/o la prescripción recomendada.

Antes de entrar al Kinder, se le debe hacer un examen de los ojos al niño/a. Si el niño/a usa gafas o lentes de contacto, se recomienda que tenga un examen de la vista todos los años y si no usa ninguna prescripción, entonces debe hacerse revisar cada 2 años. **El doctor de los ojos puede atender otros miembros de la familia, haciendo una cita.**

**Muchas gracias.**

**Student was tested with eye chart**
[ ] HOTV Chart  [ ] LEA Symbols Chart

<table>
<thead>
<tr>
<th>Right Eye</th>
<th>Left Eye</th>
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</thead>
<tbody>
<tr>
<td>Distance Vision</td>
<td>[ ] Pass</td>
</tr>
</tbody>
</table>

[ ] Student was tested with SPOT vision screener.

**Student was tested with SPOT Vision Screener:**

<table>
<thead>
<tr>
<th>Right Eye</th>
<th>Left Eye</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Vision Test</td>
<td>[ ] Pass</td>
</tr>
</tbody>
</table>

**PARA USO EXCLUSIVO DEL DOCTOR: RESULTADOS FINALES DE LA EVALUACIÓN:**

**PADRES: POR FAVOR DESPREnda ESTE FORMULARIO Y DEVUELVALO AL MAESTRO DE SU HIJO/A O A LA SECRETARIA DE LA ESCUELA.**

- Mi hijo/a tuvo una reevaluación con Dr. ______________ en esta fecha: ______________.
- Mi hijo/a tuvo un examen de la visión en esta fecha: ______________.
  ____ Se recomendaron gafas o lentes de contacto.
  ____ No se recomendaron gafas o lentes de contacto.

**NOMBRE DEL NIÑO/A:** __________________________ **NOMBRE DE LOS PADRES:** __________________________

**TELéFONO DE LA CASA:** __________________________ **TELEFONO TRABAJO/CELULAR:** __________________________
Dear Parent:

We recently sent you a letter indicating that your child was unable to pass the school vision screening and that either a full eye examination or a more thorough refractive screening was recommended. In order to measure the effectiveness of our vision screening program, we are asking you to CHECK ALL THE APPROPRIATE BOXES BELOW and RETURN THIS FORM TO THE SCHOOL, either by sending it to your child's teacher, or by mailing it to the school secretary at the above address.

( ) My child had an eye exam on the following date ________________.

( ) No glasses were recommended.

( ) Prescription glasses or contact lenses were prescribed.

( ) My child had an eye exam within the last six months and no vision problems were found, therefore I did not take my child for another eye exam.

( ) I cannot afford an eye exam for my child, please call me so that other arrangements can be made.

( ) My child had a further screening with one of the optometric consultants for Cobb County School District. Name of optometrist: ___________________________________________

( ) My child passed the screening and no further examination was necessary.

( ) My child was unable to pass the screening and a full eye exam was recommended.

PARENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Parent Name: __________________________________________

Home Phone: __________________ Work Phone: __________________

Thank you for your assistance,

Sincerely,

_______________________________________________

NOTE: If you wish to verify the need for an eye examination, the district will provide a professional re-screening to you at no charge. This is a more thorough screening, performed by an eye doctor, but is not a full eye exam.

To schedule a professional re-screening, you may contact:

<table>
<thead>
<tr>
<th>Dr. Ivo Horak, OD, Eyes R Us Family Optical, 735 Windy Hill Road, Smyrna, GA 30080 (770) 439-9123</th>
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FOLLOW-UP VISION SCREENING LETTER VS-2

ATTACH SCHOOL LETTERHEAD BEFORE PHOTO-COPYING

NOMBRE DEL ESTUDIANTE ___________________________ FECHA __________________

Apreciables Padres de Familia:

Recientemente le enviamos una carta en donde le informábamos que su hijo/a no había pasado la evaluación de la vista en la escuela y que se le recomendaba un examen completo de la visión o una evaluación refractiva. Para poder medir el nivel de efectividad de nuestro programa de evaluación de la vista, le pedimos que MARQUE LAS RESPUESTAS APROPIADAS y QUE DEVUELVA ESTE FORMULARIO A LA ESCUELA, enviándolo al maestro de su hijo/a o enviándolo por correo a la secretaría de la escuela.

( ) Mi hijo/a tuvo un examen de la visión en esta fecha ________________.

( ) No le recomendaron gafas

( ) Le prescribieron gafas o lentes de contacto.

( ) Mi hijo/a tuvo un examen de la visión en los últimos seis meses y no le encontraron problemas de la vista, por lo tanto no he llevado a mi hijo/a a otro examen de la visión.

( ) No puedo pagar por un examen de la vista para mi hijo/a, por favor llámeme para buscar una solución.

( ) Mi hijo/a tuvo una cita de seguimiento con uno de los optómetras del Cobb County School District. El nombre del Optómetra es: ____________________________

( ) Mi hijo/a paso la evaluación y no fue necesario un seguimiento.

( ) Mi hijo/a no paso la evaluación y se recomendó una evaluación complete de la visión.

PADRES, POR FAVOR COMPLETEN LA SIGUIENTE INFORMACION:

Nombre de los Padres: ______________________________

Teléfono de la Casa: ____________________ Teléfono del Trabajo: ____________________

Gracias por su ayuda,

Atentamente, ______________________________

NOTA: Si desea verificar la necesidad de un examen completo, el distrito le ofrece una reevaluación profesional, sin ningún costo. Este es un examen más minucioso, realizado por un doctor de la vista, pero no es un examen completo.

Para hacer una cita de reevaluación, comuníquese con:

Dr. Ivo Horak, OD, Eyes R Us Family Optical, 735 Windy Hill Road, Smyrna, GA 30080 (770) 436-9123

Dr. Davison acepta Medicaid y otros planes de salud y visión y habla español.

Dr. Janelle Davison, OD Brilliant Eyes Vision Center, 1680 Powder4 Springs Rd., Ste. 101 Marietta, GA 30064 (770) 428-0414

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Dr. Dean Mobley, OD Mobley Eye Care 3999 Austell Road Suite 1003 Austell, GA 30106 (770) 941-2323

Dr. Mobley acepta Medicaid y otros planes de salud y visión y habla español.

Por favor digale a la secretaria de la oficina del doctor, que usted quiere programar una "cita de evaluación del Cobb Conty School". Este no es un examen completo de la visión, es más una reevaluación para determinar si se necesita un examen completo.

Si le recomiendan un examen completo de la visión, usted debe programar una cita para que su hijo/a sea visto por Dr. Horak, Dr. Davison, o Dr. Schirack – o cualquier doctor que usted escoge. El costo del examen completo de la visión, de los tratamientos o de las recomendaciones, es responsabilidad de los padres. Si tiene un seguro de salud, debe chequer su plan para ver si cubre el costo del examen y/o la prescripción recomendada.

VS-2 Translated by IWC
Dear Parents:

The following letter is to inform you about the VISION SCREENING PROGRAM conducted for our students. We want you to understand that this is not a substitute for a complete vision examination, but rather serves as a method for us to screen our students and suggest further care for those who may have problems with their vision.

We are requesting permission to perform a vision screening with your child at your child's school. If your child is able to pass this screening, no further information will be sent to you. However, if your child is unable to pass the vision screening, a letter will be sent to you in approximately three weeks advising you of the results and recommendations.

Thank you for your assistance.

Sincerely,

I hereby grant my permission for a vision screening of my child by representatives of Cobb County School District.

Parent or Guardian Signature: __________________________________ Date: ________________

Please return to your child’s teacher.
PERMISSION FOR REFERRED STUDENTS - SPANISH

(ATTACH SCHOOL LETTERHEAD HERE BEFORE PHOTO-COPYING)

Nombre del estudiante __________________________ Fecha ______________________

Estimados padres:

La presente carta es para informarles sobre el PROGRAMA DE EXAMEN DE LA VISTA dirigido hacia nuestros estudiantes. Es importante que ustedes entiendan que este examen no sustituye un examen visual completo, sino que sirve como instrumento para examinar a los estudiantes y sugerir medidas de seguimiento médico a aquellos que posiblemente tengan problemas visuales.

Le queremos pedir permiso para hacerle un examen de la vista a su hijo(a), el cual será efectuado por voluntarios del PTA (Asociación de padres y maestros) y/o maestros de la escuela de su hijo(a). Si su hijo(a) pasa este examen, no será necesario enviarle información adicional. Sin embargo, si su hijo(a) no pasa este examen de la vista, le enviaremos una carta en aproximadamente tres semanas informándole de los resultados y recomendaciones.

Gracias por su ayuda.

Atentamente,

Firma del padre, madre o guardián __________________________ Fecha ______________________

Por este medio doy permiso para lo siguiente:

Un examen de la vista a mi hijo(a), efectuado por los representantes de las Escuelas Públicas del Condado de Cobb.

Por favor devuelva esta carta al PTA de la escuela de su hijo(a).

(VS-3)
COBB COUNTY SCHOOL DISTRICT
HEARING AND VISION SCREENING
Totals Reporting Form

TO: Dr. Cindy Fleming, Audiology-Special Student Services (Kennesaw Warehouse)
FROM: __________________________
DATE: __________________________
RE: Hearing and Vision Screening

(This form is to be completed and sent to Cindy Fleming at Audiology/Kennesaw Warehouse cindy.fleming@cobbk12.org by January 12, 2019. Thank you.)

<table>
<thead>
<tr>
<th>HEARING:</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Total number screened</td>
<td></td>
</tr>
<tr>
<td>Total number failures for first screening</td>
<td></td>
</tr>
<tr>
<td>Total number failures for second screening</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VISION:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number screened</td>
<td></td>
</tr>
<tr>
<td>Total number failures for first screening</td>
<td></td>
</tr>
<tr>
<td>Total number failures for second screening</td>
<td></td>
</tr>
</tbody>
</table>

________________________________________________________________________________________

Signature

________________________________________________________________________________________

School
CONTACT INFORMATION FOR SCREENING OPTOMETRISTS

Cobb County School District has an agreement with four local optometrists to perform re-screenings at no charge to students who have failed the Cobb County School District vision screening. This is not an eye exam, it is only a screening to determine if an eye exam is recommended. This service is not available to charter school students. The Cobb County School District will not pay for eye exams, follow-up care, or corrective lenses. For a re-screening, please contact one of the following optometrists.

Dr. Ivo Horak, OD  
CCSD Vision Consultant  
Eyes R Us  
735 Windy Hill Road Smyrna, GA 30080  
(770) 436-9123

Dr. Janelle Davison, OD  
Brilliant Eyes Vision Center  
1690 Powder4 Springs Rd., Ste. 101  
Marietta, GA 30064  
(770) 428-0414

Dr. Barry Schirack, OD  
ProCare Eye Center  
6572 Hwy. 92 Ste. 100  
Acworth, GA 30102  
(770) 924-3355

Dr. Dean Mobley, OD  
Mobley Eye Care  
3999 Austell Road  
Suite 1003  
Austell, GA 30106  
(770) 941-2323
EYE EXAMINATION RESOURCE GUIDE

Upon receiving a vision screening referral (V-1) letter from the school, parents may take their child for a professional re-screening, using one of the three doctors identified on page 4. Cobb County School District pays for this professional re-screening.

Parents may also choose to have a full eye examination for their child. Parents may choose to have a full eye exam with any of the three doctors listed, or choose their own Optometrist or Ophthalmologist. **Cobb County School System does not pay for full eye examinations or follow-up treatment for children who have failed the school screening.** Parents can seek care for their child by paying for it privately or by using vision insurance if they have coverage.

There may be some families who do not have the resources to seek further care. We have outlined some options for those families who have economic difficulties. The school counselor and/or school social worker can assist these families, as well.

1. Medicaid Amerigroup, Peachstate Health Plan, Wellcare and Peachcare for Kids:
   a. If a family has a child enrolled in any of these state funded programs, the child is eligible for a routine eye examination and one pair of prescription glasses once every 12 months. Families are encouraged to contact Amerigroup, Peachstate, Wellcare, Medicaid or Peachcare for Kids directly to locate a provider in their area. They may also check the yellow pages for a provider.
   b. To see if a family would qualify for any of these programs, parents may contact the Georgia Department of Children and Family Services for details.

2. Sight For Students Program
   a. Administered by VSP (Vision Service Plan), Sight for Students provides for an eye examination and a pair of prescription glasses. There are multiple providers in the county.
   b. The family must meet income level of 200% of poverty level or less and not have any other type of vision insurance. Applicants must be able to present either check stubs to verify Year-to-Date income or a tax return.
   c. The student must be a U.S. citizen or a legal alien and have a social security number.
   d. Contact Anne Coyle, CCSD Nursing Supervisor (770-426-3482), or Laurie Irby at Prevent Blindness Georgia (404-66-0071) for details and a certificate for this vision benefit.

3. Lions Lighthouse
   a. The Lions Lighthouse has a program to fill a prescription for glasses if a child has already had an eye examination and has a valid prescription for glasses. The patient cost for the glasses is about $39.00. Contact the Lions Lighthouse at (404) 325-3630.

4. **Eye doctors to consider:**

| Dr. Ivo Horak, OD, Eyes R Us Family Optical, 735 Windy Hill Road, Smyrna, GA 30080 (770) 436-9123 | Dr. Janelle Davison, OD Brilliant Eyes Vision Center 1690 Powder4 Springs Rd., Ste. 101 Marietta, GA 30064 (770) 428-0414 | Dr. Barry Schirack, OD ProCare Eye Center 6572 Hwy, 92 Ste. 100 Acworth, GA 30102 (770) 924-3355 | Dr. Dean Mobley, OD Mobley Eye Care 3999 Austell Road Suite 1003 Austell, GA 30106 (770) 941-2323 |
| Dr. Horak accepts Medicaid and many other vision and health plans, and is fluent in Spanish. | Dr. Davison accepts Medicaid and many other vision and health plans, and has staff who speak Spanish. | Dr. Schirack accepts Medicaid and many other vision and health plans. | Dr. Mobley accepts Medicaid and many other vision and health plans, and has staff who speak Spanish. |
SPECIAL EDUCATION and VISION - INFORMATION FOR TEACHERS

Students who are normally-sighted, and who are not served via special education are students, who have no vision concerns or whose vision can be corrected to 20/30 or better, and who are enrolled in general education classes. The standard vision screening and referral procedures are implemented for these students.

Students who are normally-sighted, and who served via special education are students who have no vision concerns or whose vision can be corrected to 20/30 or better, and who are enrolled in a special education program.

Students must pass a vision screening before being evaluated for special education eligibility or being given a psychological evaluation. This includes a distance vision and/or a near vision screening (near vision procedures are not included in this manual). For students with adequate comprehension abilities who are unable to pass the vision screening, follow the guidelines as outlined above for general education students.

Some students may be unable to understand, respond to, or comprehend the vision screening instructions. If little or no response to the vision screening is received, then the student does not need to be re-screened at school. The referral letter (V-1) and a blank copy of the Georgia Eye Report (next page) should be sent to the parent indicating that their child was unable to participate in the standard screening procedures. A complete vision examination is recommended. Parents may select an eye doctor of their choice, an optometrist or ophthalmologist, or one of the Cobb County School Optometric Consultants. The cost of the full eye exam is the responsibility of the parent.

If the parent states that the student has had a vision examination within the past year, or that the parent will be taking their child for an eye examination, the teacher should request that the parent complete the Georgia Eye Report (next page).

Using this form will encourage the reporting and sharing of needed information with the teachers, educational consultants and the school. Let the parent know that any additional educational and psychological testing will be delayed until the vision results are obtained.

Visually impaired students are students with vision that cannot be corrected to 20/70 or better in at least one eye with glasses or contact lenses. These students may already be served by the Vision Impaired Program, or may need to be referred. Reasons for vision loss are generally due to an eye injury or eye disease. Students who are visually impaired will not be able to respond appropriately to HOTV or SPOT Vision Screener. For these students an additional vision screening will not yield further useful information. Contact the Vision Supervisor for the Cobb School District (Dr. Bobbie Ealy at 770-426-3497) to discuss further testing.

For further information or clarification on specific vision referral procedures, please contact Dr. Bobbie Ealy, Special Education (770-426-3497); or email Bobbie.Ealy@cobbk12.org.
# Georgia Instructional Materials Center

## Eye Report for Vision Services & APH Registration

### Section 1: Demographics

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>DOB:</th>
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<table>
<thead>
<tr>
<th>School System:</th>
<th>Date of Current Eye Exam:</th>
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</table>

### Section 2: Eligibility for Vision Services and Federal Quota Fund Registration (mark all that apply)

- [ ] Visually Impaired (VI) 20/70 or less in the better eye after correction or there is a limited visual field that could adversely affect educational progress.
- [ ] Meets the Definition of Blindness (MDB) 20/200 or less in the better eye after correction or visual field no greater than 20 degrees.
- [ ] Meets the Definition of Blindness (MDB) Immutable Condition (bilateral enucleations, etc)
- [ ] Functions at the Definition of Blindness (FDB) Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment.

### Section 3: Visual Diagnosis & Prognosis

<table>
<thead>
<tr>
<th>Diagnosis:</th>
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<thead>
<tr>
<th>Prognosis:</th>
<th>[ ] stable</th>
<th>[ ] unstable</th>
<th>[ ] capable of improving</th>
<th>[ ] uncertain</th>
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</table>

### Section 4: Acuities & Visual Fields

If unable to obtain Snellen Acuity, consider the FDB criteria

<table>
<thead>
<tr>
<th>Distance Acuity (ft.)</th>
<th>Near Acuity (in.)</th>
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<tbody>
<tr>
<td>O.D.</td>
<td>O.S.</td>
</tr>
<tr>
<td>O.U.</td>
<td>O.D.</td>
</tr>
<tr>
<td>O.S.</td>
<td>O.U.</td>
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</table>

- Corrected
- Without Correction

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<thead>
<tr>
<th>Counts Fingers:</th>
<th>[ ] O.D</th>
<th>[ ] O.S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Movement:</td>
<td>[ ] O.D</td>
<td>[ ] O.S</td>
</tr>
<tr>
<td>Object Perception:</td>
<td>[ ] O.D</td>
<td>[ ] O.S</td>
</tr>
<tr>
<td>Light Perception:</td>
<td>[ ] O.D</td>
<td>[ ] O.S</td>
</tr>
</tbody>
</table>

Is there a field limitation? [ ] Yes [ ] No
If yes, please describe: ____________________________

Please attach diagram of visual fields if tested.

### Section 5: Prescription

Complete if glasses and/or contact lenses prescription issued

- OD: sphere ________ Cylinder ________ Axis ________
- OS: sphere ________ Cylinder ________ Axis ________

- Glasses: [ ] To be worn constantly [ ] for close work only [ ] for distance only [ ] for protection

### Section 6: Surgery, medications:

<p>| |</p>
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### Section 7: Recommendations

(lightening levels, restrictions, attach additional pages if necessary)

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### Section 8: Authorizations

- Doctor’s Name Printed: ____________________________
- Name of Practice: ____________________________
- Doctor’s Signature: ____________________________ MD or OD (circle one)
- Parent/guardian Signature: ____________________________ Date: __________________

I authorize the above person to release this information for educational purposes.