LOS ANGELES UNIFIED SCHOOL DISTRICT
ADMINISTRATIVE OFFICES
333 South Beaudry Avenue, 24th Floor
Los Angeles, California 90017
Telephone: (213) 241-7000 | Fax: (213) 241-8442

ALBERTO M. CARVALHO
Superintendent

LAUSD Vision Screening Opt-out

Dear Parent/Legal Guardian/Educational Rights Holder (Parent) of a LAUSD student,

Your child's school may have the opportunity to host a free on-site **EYE EXAMINATION** by a licensed healthcare professional. The purpose of this screening event is to identify your child's vision needs, connect to care, and eliminate health barriers to learning. Note: Screening events are supplemental to, and do not replace, any legal requirements for vision health required by EC Section 49455. If your child is screened and found to have an urgent problem, your child will be sent home with a letter. If you receive a letter, it is important that you take your child to an eyecare provider for an evaluation.

VISION

Participating in a school vision screening has many benefits:

- ✓ You do not need to take time off from work.
- ✓ No missed workdays for you or missed school days for your child(ren).
- ✓ **FREE** eye examination by a licensed professional.
- ✓ **FREE** prescription eyeglasses, if needed.

For more information about the free on-site eye exams, please scan this QR code:
or visit: http://achieve.lausd.net/visionscreening.

If you *want* your child to receive a free eye examination, NO FURTHER ACTION IS NEEDED. Your child's name, date of birth, grade, school name, and your name, phone number, and address will automatically be shared with the health professional(s) conducting the screening.

If you *DO NOT* want your child to receive a free eye examination, please complete the portion below of this letter and return it to your child's school ***by the second week of September***. Forms received *after* this deadline may result in services being rendered. *Only complete and sign the Form directly below this line if you **do not** want your child to receive an eye examination.*

Student's Name: _____ DOB: _____

☐ I **DO NOT** wish to have my child participate in the school's free on-site vision screening.

_____ _____
**Parent Signature* *Date*

For students experiencing homelessness, under California law, families **must opt in to share information. If you would like your child to participate, you can authorize LAUSD to share information with the licensed healthcare professional by completing the info below and sending a copy of this form to your child's school **no later than the first week of September.***

_____
**Print Parent Name*

_____ _____
**Parent Signature* *Date*

_____ _____
**Print Student Name* and birthdate (mo./day/year) *Name of School*

For Office Use Only: To input information into MiSiS -> Miscellaneous tab -> Health Screening->Scroll Middle of Page- External Partner Dental (select from drop down menu)-Opt-in