



2023

Dear Parent or Guardian:

Lighthouse for the Blind-St. Louis is excited to share with you our low vision program, the Children's Low Vision Project (CLVP). The purpose of CLVP is to provide school age children who are visually impaired, ages 2-21, with clinical low vision evaluations, prescribed optical devices, and instruction in device use.

Your child will receive, at no cost to you or your child's school district, a comprehensive low vision evaluation, a complete written report with recommendations for appropriate low vision devices, any devices prescribed, and instruction in the use of those devices as necessary. Should a new prescription for eyeglasses be recommended, CLVP may purchase the new pair of glasses during the year your child participates in the program but not each year thereafter.

A child may be referred to the program by family, teachers, or their primary eye care provider. Upon referral, the child's education team is asked to provide the child's most current visual assessments as well as an updated eye report and any vision related IEP goals. A child is scheduled for their clinical low vision evaluation at the clinic location closest to the city in which they reside. Family members, teachers of students with visual impairments, and certified orientation and mobility specialists are encouraged to attend the low vision evaluation to provide valuable insight on the child as well as to obtain knowledge of the recommendations prescribed. The services provided by CLVP do not take the place of regular visits to the child's primary eye care provider, such as his or her ophthalmologist or optometrist.

Should you have any questions regarding the information above or would like to refer your child for a low vision evaluation, please do not hesitate to contact Ashley Bement, Program Manager: [abement@lhbindustries.com](mailto:abement@lhbindustries.com) or 618-612-9412; or Izzy Breiter: [ibreiter@lhbindustries.com](mailto:ibreiter@lhbindustries.com) or 507-327-0388.

CLVP looks forward to working with you and your child.

Sincerely,

Ashley Bement, M.Ed.  
Program Manager



**Permission and Record Release Form**

I have read this consent letter and understand the purpose and procedures of this project. I freely and voluntarily choose to participate and to have my son or daughter participate. I agree to allow the school system/doctor's office to release information regarding my child's vision, i.e. most current functional vision assessment, ophthalmology report, orientation and mobility evaluations and IEP goals and objectives.

I authorize and give permission to the Children's Low Vision Project/Lighthouse for the Blind – St. Louis to obtain or provide information to my child's school district, optometrist/ophthalmologist, Delta Gamma Center, UMSL Center for Eye Care, and/or Rehabilitation Services for the Blind (RSB) for programming and collaboration. Low vision evaluation information will be kept confidentially with the CLVP director and staff.

I give permission for my child's photograph to be used by the Children's Low Vision Project/Lighthouse for the Blind– St. Louis for advertising purposes such as brochures, newsletters, press releases, video snippets, or written stories.

To ensure the safety of all program participants, Lighthouse kindly asks that students adhere to the following policies for the duration of our programs:

No use of tobacco products, including cigarettes, smokeless tobacco, and electronic cigarettes.

No use of alcohol, inhalants, or drugs.

No viewing or sharing of pornography including images, videos, and/or photos that include nudity.

No weapons of any kind.

For Completion by the Parent or Guardian (if participant is **under** 18 years of age):

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Child's School & District

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
TVI and O&M Name

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_/\_\_\_\_\_  
Printed Name of Parent or Guardian      Relationship to Child

\_\_\_\_\_  
Street Address, City, State, Zip Code

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Preferred Phone Number

Eye Doctor's Name: \_\_\_\_\_