



MOBILE VISION SERVICES CONSENT AND RELEASE FORM

Dear Parent/Guardian,

Vision To Learn is a nonprofit that offers eye exams and glasses to kids at no cost. Vision To Learn will be bringing its mobile vision care clinic to your child's school to provide eye exams and glasses to children who need them. If you would like to give your child permission to participate in the Vision To Learn program, please complete and sign this form. Return the completed form to the school office.

There is no cost for your child to participate in the program.

PLEASE PRINT OR TYPE:

<u>REQUIRED:</u>			
Child's First Name: <input type="text"/>		Child's Last Name: <input type="text"/>	
Child's Date of Birth:	Month <input type="text"/>	Date <input type="text"/>	Year <input type="text"/>
Parent/ Guardian First Name: <input type="text"/>		Parent/ Guardian Last Name: <input type="text"/>	
		Child's Gender (please check one): <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	

CONTACT INFORMATION:

Street Address:	Unit/ Apt:	City:	State:	Zip:
Phone Number:	Emergency Phone Number:	Email:		

SCHOOL INFORMATION:

Name of School:	Name of Teacher:
Grade:	Classroom:

OPTIONAL:

INSURANCE INFORMATION:

Child Has Medi-Cal

Provider (circle one):	L.A. CARE HEALTHNET	I.D. Number:
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Child Has Private Insurance

Provider:	I.D. Number:
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Child Is Uninsured

By signing this form, if my child fails their vision screening, I agree to allow my child to receive care services through Vision to Learn's mobile vision clinic. I acknowledge that I have the right to refuse any services provided by Vision To Learn but that I am choosing voluntarily for my child to receive vision services. I understand that receiving vision services through Vision To Learn's mobile vision clinic will not disqualify me from accessing services for vision care through my insurance. I agree that I am waiving any and all claims against the school of which my child is a participant that may arise from my child's participation in the Vision To Learn program. My signature shows that I have read and understood this voluntary Consent and Release and I agree to its provisions.

Yes, give permission for my child to be examined by Vision To Learn.

Parent/Guardian Signature: _____ Date: _____

No, I DO NOT give permission for my child to be examined by Vision To Learn.