2019-2020 School Year Consent Form

FREE eye EXAM and GLASSES for your child!

EYE THRIVE

Eye Thrive operates a state-of-the-art Mobile Vision Clinic that provides free eye exams and prescription glasses at schools and community centers throughout our community. This free health service is authorized by your child's school administration and coordinated by your child's school nurse. **Your child is only eligible to receive this free service if they have 1.) Failed their vision screening or currently wear glasses 2.) Qualify for Free and Reduced Lunch or are enrolled in Medicaid.**

I want my child to get an eye exam and glasses at NO COST.

Child's Name _____ Date of Birth _____ Gender M F

Street Address _____

City _____ State _____ Zip code _____

Phone Number _____ School _____Grade_____

Child's Ethnicity African American Asian Biracial Caucasian Eastern European
Hispanic Latino Native American Other _____

Is your child enrolled in Medicaid? (circle one) NO YES If yes, my child's Medicaid ID is: _____

Is your child enrolled in Free or Reduced Lunch? (circle one) NO YES

Your signature authorizes our licensed optometrist and staff to conduct an eye examination (with drops if needed) and prescribe and dispense eyewear (if needed). You are also authorizing full disclosure of the results of your child's eye examination. This information may be shared with the following individuals: yourself, your child's school nurse, and any specialist we may refer your child to for follow-up and continuity of care. You are also giving permission to verify Medicaid eligibility and if applicable bill Medicaid for the eye examination only.

Parent/Guardian SIGNATURE _____

Parent/Guardian Printed Name _____

Your signature allows your child to be photographed or filmed solely for the promotion of Eye Thrive.

Parent/Guardian SIGNATURE _____

Child's Health History

Please circle all that apply:		Details:
Has your child ever received an eye exam?	Yes No	_____
Has your child ever been prescribed glasses? How long ago?	Yes No	_____
Does your child wear glasses now?	Yes No	_____
Does your child complain of blurry vision?	Yes No	_____
Has your child ever injured or had surgery on his/her eyes?	Yes No	_____
Please list any medications your child is currently taking.		_____
Please list any food or medication allergies your child has.		_____
Please list any illnesses your child has been diagnosed with. (diabetes, cancer, heart disease, or autoimmune disease)		_____

Return this form to your child's school. If you have any questions, please contact your child's school nurse.