EYE THRIVE

Improving futures through sight

Dear Parent/Guardian,

It has come to my attention that your student is in need of vision services due to:

☐ failing a recent vision screening completed at school
☐ broken/lost glasses

To assist you in accessing vision care for your student, I would like to offer services through Eye Thrive. For more information, go to http://www.eccoma.org/ . Eye Thrive will conduct a comprehensive vision exam and, if needed, a new pair of glasses will be made specifically for your student.

Eye Thrive's Mobilized Vision Clinic will be parked at a Parkway school. Students from surrounding schools will be transported to and from the clinic by Parkway buses. Your student will be supervised by a Parkway School Nurse throughout the entire process.

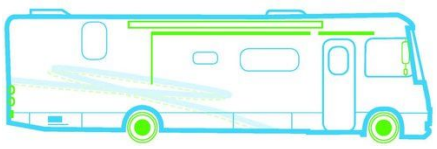
If you are interested in having your child participate in this vision clinic, complete the attached *Eye Thrive Consent Form* **and** the F*ield Trip Permission* form. Return these forms to me as soon as possible. Please, do not hesitate to contact me with any questions or concerns.

_____
School Nurse

_____
School

_____
Nurse's Email

_____
Nurse's Phone Number



EYE THRIVE

2019-2020
Replacement Request Form

To request a replacement pair of glasses please complete the form below. We can only provide replacements for valid prescriptions (within one year of Eye Thrive exam). After submitting your request please allow 2-3 weeks for delivery of glasses.

Date of Request _____

Child Name _____

Child Date of Birth _____

Date of Eye Thrive Exam _____

School Nurse Name _____

School Name _____

School Address _____

_____

School Phone Number _____

What is the reason for replacement? ☐BROKEN ☐LOST ☐Other: _____

Please Return to Eye Thrive.

Fax - 314-736-1425 Email - info@eyethrive.org Phone - 314-736-1400

For Eye Thrive use ONLY

Original Frame Info:

Size: _____

Color: _____

Material: _____

Lab Location: _____

Date Form Received: _____

Date Job Ordered: _____

Date Job Checked-in: _____

Final Verification Initials: _____

Date Job Mailed: _____

Teacher/Team/Department: Health Services

PARKWAY SCHOOL DISTRICT
PARENT GUARDIAN CONSENT FOR SCHOOL-SPONSORED TRIP

I give permission for my son/daughter, (name) _____ to go to the following school-sponsored trip/s: Eye Thrive Mobile Vision Clinic

on (date of trip/s) _____

Home Phone Number _____ Cell Phone Number: _____

Work Phone Number: _____

Emergency Contact: _____ Phone#: _____

MEDICAL INFORMATION:
Send _____ medication, taken daily at school, on this field trip, to be administered by school staff at _____ ☐a.m./☐p.m.
Send _____ medication, taken on an as needed basis at school, on this filed trip, to be administered by school staff according to the directions on file.

Only those students who have the top portion of this form properly signed and returned to school by (date) _____ will be granted permission to participate in the field trip.

All students are expected to **comply with the supervisor's instructions** while enroute to/from and during the time of the school-sponsored activity.

Emergency Authorization: In an emergency, I hereby authorize the school to make such arrangements as necessary. I also authorize the hospital/physician/dentist to perform necessary procedure.

** _____ ** _____
Signature of Parent/Guardian Date Signed

✂---------- ✂----------✂

(Parents may detach and retain this portion of the form for information.)

The Trip begins at _____ ☐a.m. ☐ p.m. on _____ (Date)

The students will return to school at _____ ☐a.m. ☐ p.m. on _____ (Date)

The following teacher/s will accompany the group: Parkway School Nurses

Transportation will be provided by: Parkway School District

Cost of the Trip: N/A **(Make check payable to Parkway School District)**

Student should bring lunch: ☐ Yes ☑ No.