Grades K-12*!
EYE EXAM and GLASSES for your child at NO COST
*k-12 In selected school districts
www.kidsvisionforlifestlouis.com

If your child does not pass his/her vision screening, they will qualify to receive an eye exam from an optometrist and a pair of glasses from Kids Vision for Life St. Louis at NO COST.

If needed, I want my child to get a vision exam and glasses at NO COST.

Student's Name ____ Date of Birth_________________

School Name____

Insurance Provider and ID Number ____________________________________ Gender: M F

Parent/Guardian **SIGNATURE** _____________________________________ Date_________________

Parent/Guardian **Printed Name**____

I agree to allow my child to be photographed or filmed solely for the promotion of Kids Vision for Life St. Louis_____________(Initials)

IMPORTANT: Free Eye Exam and Free Glasses are ONLY valid at the time of Kids Vision for Life's visit to your school. This sheet may NOT be presented at any Crown Vision Center location for services or materials.

Patient Health History

Please circle all that apply:		Details:
Did your child receive an eye exam last year?	Yes No	
Does your child wear glasses?	Yes No	
Are there any problems with his/her vision?	Yes No	
Has your child ever injured his/her eyes?	Yes No	
Does your child suffer from any medical conditions?	Yes No	
Do any of your family members suffer from any medical conditions?	Yes No	
Does your child currently take any medication?	Yes No	
Is your child allergic to anything?	Yes No	

I hereby authorize Crown Vision Centers and their licensed Optometric staff to conduct a comprehensive eye examination on my child and, if needed, to prescribe and dispense spectacle eyewear. I am hereby authorizing **FULL** disclosure of the results of my child's vision exam, provided by Crown Vision Center and/or its partners. This information may be shared only with the following individuals: **Myself**, **My child's school nurse, Crown Vision Center, Essilor Vision Foundation, American Optometric Association, and the State of Missouri.** I understand that I may, at any time remove this authorization in writing, however, by doing so I understand that this will take away any services provided by Crown Vision Center & its partners. I understand if an unauthorized disclosure is made, I may file a formal complaint with the United States Department of Health and Human Services.

By signing this form and giving permission to examine your child and potentially provide eyewear; You are also giving permission to verify Medicaid eligibility and if applicable bill Medicaid ONLY.

COMMUNITY PARTNERS: