Mobile Vision Consent Form: EYE See Clinic by Near Vision Institute (non-profit)

APPLICATION / CONSENT: PLEASE COMPLETE, SIGN, AND RETURN TO SCHOOL IMMEDIATELY.

- Your student can receive a **COMPREHENSIVE EYE EXAM** by our eye doctor at school during the 2022-2023 school year.
- If prescribed, your child will be fitted with glasses which will be dispensed at school.
- Services are provided by EYE See Clinic of 12835 Bel-Red Rd, Suite 303 Bellevue, WA 98005: www.EYESeeClinic.org

Child's First and Last Name_____ Date of Birthday____/____/____

Sex □FEMALE □MALE Phone Number_____ Email _____

Race (Circle all that apply): White, Black/African American, Asian, Native American, Unknown, Other: _____

Mailing Address_____ City_____ Zip Code_____

School_____ Grade_____ Teacher_____ Rm #_____

Does your child have an IEP or 504 plan? □ Yes □ No

PLEASE CHECK YES OR NO AND COMPLETE THE FORM AS INDICATED:

☐	YES, I have read the information about the vision care program and I give my informed consent for my child to participate in the Mobile Vision Clinic event. I understand my child will receive an eye exam and glasses, if needed, which may require the use of dilation drops. Please complete the rest of this form, both PRINT & SIGN at the bottom and return it to school.
☐	NO, I do not want my child to receive an eye exam. Parent/Guardian Signature_____ Date_____/_____/_____

Please tell us a little more about your child:

Has your child's vision been evaluated by an optometrist or ophthalmologist? □ No □ Yes

Date of Last Eye Exam____/____/_____ Where?_____

Does your child wear glasses? □ No □ Yes For: □ Full-time wear □ Distance only □ Near only

Does your child have a history of patching? □ No □ Yes

Please list any significant medical diagnosis _____

List any medication your child takes _____Allergies to medication_____

Our program is partly funded by government agencies, grants, and donations. WE WILL BILL INSURANCE FOR SERVICES

If you have a **Medicaid / Apple Health** plan check here □Yes –> There are no fees for the exam or glasses if needed.

If you have a **different vision or medical insurance**, please list here: **Vision plan**_____

Medical plan _____ We will check eligibility and let you know if we can help.

Primary Insured Name_____ Primary Insured date of birth: _____/_____

Income: Which of these best represents your annual household income? **(Circle one)**

Less than $20,000 | $20,000 - $40,000 | $40,000 - $60,000 |$60,000 - $80,000 | More than $80,000

Total Household Size _____ (include yourself, significant other, and children)

We triage services based on need and access. We strive to see everyone who requests services, but may need to limit the number we can serve in some cases. Let us know if there are exceptional circumstances and we will try our best to help.

I have read and completed the information on this form and my signature below gives consent for the exam and is valid for this school year. I have read and understand the Notice of Privacy Practices, where a copy can be found at www.eyeseeclinic.org. This form, when signed and filled in, contains Protected Health Information and the information is to be protected according to HIPAA.

Print Parent/Guardian Name_____

Parent/Guardian Signature_____ Date____/____/_____