MOBILE VISION SERVICES CONSENT AND RELEASE FORM

For Office Use Only:	
Site:	*Date:*

iSEE with Vision To Learn (VTL) is a nonprofit program that offers eye exams and glasses to students kindergarten through 12th grade.
If you would like to give your child permission to participate in the VLT program, please complete and return the below form.

There is no cost to you for your child to participate.

Note that VTL could use your student's Medicaid vision benefit if receiving an eye exam, unless referred on for additional care.

Step 1: Check Requested Service

☐ **Eye Exam and Glasses as Needed**	☐ **Glasses Only**
Check *Yes or No* below if the doctor is allowed to use cycloplegic eye drops during your student's exam should they feel it necessary to relax the muscles to prescribe a more accurate prescription. Note these drops may cause your student's eyes to be sensitive to light and potentially blurry for 6-24 hours. ☐ **Yes to Eye Drops** ☐ **No to Eye Drops**	*****Action Needed: You must attach a copy of your student's eyeglasses prescription you received from you eye doctor in the last 12 months.*** *On the day of the VTL visit, your child will visit with the VTL Team to pick out a frame and glasses will arrive ~3-4 weeks later.*

Step 2: Share Student Information (One Form Per Student)

REQUIRED:

Student's First Name:

Student's Last Name:

Child's Date of Birth: Month / Date / Year

Child's Gender (Check One): ☐ MALE ☐ FEMALE ☐ NON-BINARY

Parent/ Guardian First Name:

Parent/ Guardian Last Name:

CONTACT INFORMATION:

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

INSURANCE INFORMATION (Optional):

☐ Student Has Medicaid	☐ Child Has Private Insurance
Provider:	
I.D. Number:	

Step 3: Sign and Date

By signing this form, 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. Vision To Learn provides a vision evaluation with a full refraction and is able to provide glasses to students who need them. I understand that services provided by Vision To Learn's mobile clinic program may be billed to my child's Medicaid benefits, unless my child is referred for follow-up care.

Vision To Learn sometimes collects images of participants to publicize its programs. I agree that my child may be photographed, filmed and/or voice recorded in any format (collectively called "Recordings") and that Vision To Learn will own and may use such recordings without any further permission from me without compensation to my child or my child's parents or guardians.

My signature shows that I have read and understood this voluntary Consent and Release and I agree to its provisions.

Parent/Guardian Signature:______________________________________ **Date:**______________

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