EYE THRIVE

FREE eye EXAM and GLASSES for your child!

Eye Thrive is proud to operate a Mobile Vision Clinic that provides eye exams and prescription glasses to children throughout our community at no cost.

Child's First Name:____ **Date of Birth**:____________________

Child's Last Name:____

Gender: Male Other Female Prefer Not to Say

Ethnicity: African-American Caucasian Multiple Races Other__________ Asian Hispanic Native American

Child's School:____________________________________ **District**:_________________________________ **Grade**:___________

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

Parent Cell Phone:____________________________ **Parent Email Address**:____

Home Street Address:____

City:____ **State**:_______________ **Zip Code**:__________________________

Your signature below 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.

I understand that, because an eye exam involves close physical proximity, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved in my child receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/organization from any claims related thereto.

Parent/Guardian SIGNATURE:____ **Date**:_____________________

Parent/Guardian Printed Name:____ **Relationship to Patient**:_________________

Your signature below allows your child to be photographed or filmed solely for the promotion of Eye Thrive and our partnering organizations, including VSP Global and its companies.

Parent/Guardian SIGNATURE:____

Health History:

Has your child ever received an eye exam? Yes No If yes, was it from Eye Thrive? Yes No

Has your child ever been prescribed glasses? Yes No If yes, how long ago? _________________________________

Does your child wear glasses now? Yes No

Does your child complain of blurry vision? Yes No

Has your child ever injured or had surgeries on his/her eyes? Yes No

Does your child have diabetes? Yes No

Please list any medications your child is currently taking. ____

Please list any food or medication allergies your child has. ____

Please list any medical conditions your child has been diagnosed with. ____

Please list any family history of eye disease. ____