



MOBILE VISION SERVICES CONSENT AND RELEASE FORM

Dear Parent/Guardian,

Vision To Learn is a nonprofit organization that offers eye exams and glasses to kids at no cost. Vision To Learn will be bringing its mobile vision care clinic to your child's school to provide eye exams and glasses to children who need them. If you would like to give your child permission to participate in this program, please complete and sign this form. Return the completed form to the school nurse.

There is no cost for your child to participate in the program.

Vision To Learn sometimes collects images of children it serves in order to publicize its programs. You agree that your 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 in any format without compensation to your child or your child's parents or guardians. You agree that you are waiving any and all claims against your school and Vision To Learn that may arise from your child's participation in the program or the use of the Recordings.

YES, I agree to allow my child to participate in the Vision To Learn mobile vision clinic program, described above.

PLEASE PRINT OR TYPE:

REQUIRED:			
Child's First Name:		Child's Last Name:	
Child's Date of Birth: Month	Date	Child's Gender (please check one):	
_	_	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
_	_		
Parent/ Guardian First Name:		Parent/ Guardian Last Name:	

CONTACT INFORMATION:

Street Address:		City:	State:	Zip:
Phone Number:	Emergency Phone Number:	Email:		

SCHOOL INFORMATION:

Name of School:	Name of Teacher:
Grade:	Classroom:

INSURANCE INFORMATION: **OPTIONAL:**

Child Has Medi-Cal

Provider:	I.D. Number:

Child Has Private Insurance

Provider:	I.D. Number:

Child Is Uninsured

By signing this form, I agree to allow my child to receive vision care services through Vision To Learn's mobile vision clinic. 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. I understand that receiving vision services provided by Vision To Learn's mobile clinic will not disqualify me from accessing non-mobile services for vision care. I agree that I am waiving any and all claims against the school where my child is a student that may arise from my child's participation in the program.

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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