



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 out-of-pocket 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 the Vision To Learn program, please complete and sign this form. Return the completed form to the school coordinator.

Vision To Learn follows CDC, state and federal regulations including staff daily health screenings, the use of Personal Protective Equipment for staff and students, and thorough disinfection between patients. Vision To Learn is committed to following best practices to prioritize the safety of our students.

Medicaid Benefit Usage Receiving vision services provided by this program will constitute a comprehensive eye exam and – as needed – eyeglasses and dispensing of glasses that **may be billed to your child's 2024-25 Medicaid benefits**, if applicable. Please note that a no-cost eye exam and eyeglasses will be provided even if your insurance cannot be billed. You may receive a notice called an Explanation of Benefits (EOB) from your insurance carrier with information regarding the services billed and the payments that have been approved, but you will not receive any bill for the services or eyeglasses.

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

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|---|-------------------------|-----------|-----------------------------|---|
| REQUIRED: | | | | |
| Child's First Name: PLEASE PRINT OR TYPE: | | | Child's Last Name: | |
| | | | | |
| Child's Date of Birth: | Month | Date | Year | Child's Gender (please check one): |
| | | | | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> NON-BINARY |
| Parent/ Guardian First Name: | | | Parent/ Guardian Last Name: | |
| | | | | |
| CONTACT INFORMATION: | | | | |
| Street Address: | | Unit/Apt: | City: | State: |
| | | | | |
| Phone Number: | Emergency Phone Number: | | Email: | |
| | | | | |

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 comprehensive eye exam without dilation. Vision To Learn is able to provide glasses to students who need them, but does not administer eye drops. I understand that services provided by Vision To Learn's mobile clinic may be billed to my child's Medicaid benefits, unless my child is referred for follow-up care. My signature shows that I have read and understood this voluntary Consent and Release and I agree to its provisions.

Parent/Guardian Signature: _____ Date: _____