Please complete, sign & send back to program tomorrow!

MOBILE VISION SERVICES

CONSENT AND RELEASE FORM

Vision To Learn
Focus on the Future

Dear Parent/Guardian,

Your child's program is participating with Vision To Learn (VTL), a non-profit organization that provides free eye exams and free eye glasses to children. VTL will be bringing its mobile vision clinic to your child's program. **VTL will provide exams and eyeglasses to each student who needs them, regardless of ability to pay**. This is a chance to make sure that your child can see well and is ready to learn.

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 the coordinating program and Vision To Learn that may arise from your child's participation in the program or the use of the Recordings.

VTL will conduct vision testing and, if necessary, will provide glasses for your child at no cost to you. No eye drops are needed for this exam. But we need your permission to include your child. **If you would like to have your child participate in this program, please fill in the box below and sign the form at the bottom.** Have your child take the form to his/her program tomorrow.

Child's First Name (please print)_____

Child's Last Name (please print)_____

Date of Birth (month/day/year)_____/_____/_____ **Gender** □ **Male** □ **Female**

Parent/Guardian First and Last Name (please print) _____

Street Address _____

City _____ **Zip Code** _____

Phone _____**Phone (alternate)** _____ **Email** _____

Program_____ **Instructor** _____

Medicaid Number (if applicable) _____

By signing this form, I agree to allow my child to receive a vision exam and glasses, if necessary, through VTL's mobile vision clinic. I consent to VTL electronically accessing my child's Medicaid Number and billing Medicaid (if applicable) **or my insurance for those services**. I agree that I am waiving any and all claims against the Coordinating Program that may arise from my child's participation in the program. I grant permission for Coordinating Program employees or volunteers to bring students to the mobile vision clinic to receive services during program hours. My signature shows that I have read and understand the terms of this Vision To Learn Consent and Release Form and I agree to its conditions.

Parent/Guardian Signature_____ **Date**_____