Friends for Sight
Vision Clinic Applicantion and Consent to Treat

THIS FORM MUST BE COMPLETED AND SIGNED IN ORDER FOR YOUR CHILD TO BE SEEN AT THE CLINIC.

DATE ____________

Student Information to be completed by parent or guardian

First Name	Last Name	Date of Birth dd/mm/yyyy

Street Address	Apt./Unit#	City	State	Zip

Current school

Demographic Information

Race ☐ White ☐ Asian ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander

Ehnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Gender** ☐ Male ☐ Female ☐ Self Identify ____________

Languages spoken at home	**Interpretation Needed?**	**Any other needs we should know about?**
	☐ Yes ☐ No	

Parent/Guardian Information

First Name	Last Name	Relationship to Student

Phone Number	Email	Best way to reach you?

Student Health History

Does the student have chronic health issues including heart or lung problems? ☐ Yes ☐ No

If yes, please describe

Does the student or any immediate family members (parent, grandparent, sibling) have EYE DISEASE? ☐ Yes ☐ No

If yes, what is the relationship? What is the disease or condition?

Has the student failed a vision chart screening at school. ☐ Yes ☐ No

Has the student had a full eye exam with an eye care professional in the last 12 months? ☐ Yes ☐ No

Has the student ever worn glasses? ☐ Yes ☐ No | Any known allergies? ☐ Yes ☐ No | Current Medication

Please describe any known problems or symptoms with the student's vision or EYE HEALTH.

Is the student on or eligible for the school's free or reduced lunch? ☐ Yes ☐ No Do you have insurance? ☐ Yes ☐ No

Insurance Provider (Medicaid, SelectHealth Molina, etc.)	Policy Holder's Name	Date of Birth mm/dd/yyyy	Insurance ID #

I certify that all information above is true and complete to the best of my knowledge and any misrepresentation may result in automatic termination and suspension from making future applications. I give permission for information contained herein to be collected for statistical purposes and understand that patient information will be held in the strictest confidence and will not be shared with other entities unless I give written permission. I hereby release, waive, and discharge the organization, officers, directors, employees, representatives, volunteers, agents, affiliates, and/or assigns of the independent optometrist(s) and ophthalmologist(s) who perform the eye exam, of any liability resulting from or arising out of this service. I understand and give permission for eye drops (if necessary) to be used during the exam which allows the doctor to see inside of the eye. These drops will not harm the eye/eyesight. The pupil will be larger than normal but will return to its normal size within a few hours up to a day. During this period, the patient may experience light sensitivity and blurry vision/difficulty reading. I give my permission for my child to receive an eye exam at the Friends for Sight Clinic located at Parkview Vision Clinic, Liberty CLC, or Glendale CLC.

____
Parent/Guardian Printed Name

____
Parent/Guardian Signature

____
Date

I would like the school counselor/advocate to be informed about treatment plans to coordinate follow up care. ________(initial here)

By initialing this box, I give consent for my child to be in pictures or video while participating in clinic for internal communication or advertising and promotional purposes. ________(inital here)

801-524-2020

email completed form to: clinic@friendsforsight.org