CONSENT FORM

Eye exam and glasses at no cost.

Your child DID NOT PASS their KidSight vision screening. They qualify to receive an eye exam from a Family Focus Eyecare licensed optometrist and a pair of prescription glasses at no cost.

Complete the form below if you wish for your child to get an eye exam and glasses at no cost, if needed.

PERSONAL INFORMATION

Student's Full Name :

Student's Date of Birth : / / **Student's Gender** : Male Female Other

Student's Address :

Parent/Guardian Phone : - - **Parent/Guardian Email** :

Name of School : **Student grade** :

Medicaid ID Number (if applicable) :

MEDICAL HISTORY

Does your child wear glasses? : Yes No

Did your child receive an eye exam last year? : Yes No

Has your child ever injured his/her eyes? : Yes No If yes, please explain:

Do any family members suffer from any medical conditions? : Yes No If yes, please explain:

Does your child suffer from any medical conditions? : Yes No If yes, please explain:

Is your child currently taking any medications? : Yes No If yes, please explain:

Does your child have any allergies? : Yes No If yes, please explain:

Please complete the front and back of this form and email it to KidSight at **assistance@kid-sight.org.** You may also send it via mail in the paid postage envelope provided in the referral packet.

CONSENT FORM

IMPORTANT: Free Eye Exam and Free Glasses are ONLY valid at the time of KidSight/Family Focus Eyecare's visit to your child's school. This form may NOT be presented at Family Focus Eyecare for services or materials.

I hereby authorize Family Focus Eyecare and their licensed Optometric staff to conduct a comprehensive eye examination *with dilation* on my child and, if needed, to prescribe and dispense spectacle eyewear. I am hereby authorizing FULL disclosure of the results of my child's vision exam, provided by Family Focus Eyecare and/or its partners. This information may be shared only with the following individuals: Myself, My child's school nurse, KidSight, Essilor Vision Foundation, American Optometric Association, and the State of Missouri. I understand that I may, at any time remove this authorization in writing, however, by doing so I understand that this will take away any services provided by Family Focus Eyecare & its partners. I understand if an unauthorized disclosure is made, I may file a formal complaint with the United States Department of Health and Human Services.

By signing this form and giving permission to examine your child and potentially provide eyewear; You are also giving permission to verify Medicaid eligibility and, if applicable, bill Medicaid ONLY.

Media Release Form (Minors): KidSight and Family Focus Eyecare provide this media release form in connection with its efforts to promote its programs to assist in securing additional funding and resources.

I, as the parent or guardian, grant to KidSight and Family Focus Eyecare the right to take and use photographs, audio recordings, and videos of my minor child (under the age of 18) in connection with the child's experiences with their vision programs.

I authorize KidSight and Family Focus Eyecare, its assigns and transferees, and all persons acting under its permission or authority, to copyright, use, and publish the same in print and/or electronically.

I agree that KidSight and Family Focus Eyecare may use such photographs, audio recordings, or videos for any lawful purpose including, but not limited to, marketing materials, newsletters, websites, social media (including Facebook, Twitter, Pinterest, YouTube), and/or any other advertisements or promotions they may decide to develop, now or in the future.

I hereby release and discharge the above, its assigns and transferees, and all persons acting under its permission or authority, from and against any liability that may occur in the taking of photographs, audio recordings, and videos, or reproductions of the finished products.

May we produce and distribute media (photos, videos, etc.) of your child solely for the promotion of KidSight and Family Focus Eyecare?* : ☐ Yes ☐ No

I certify that I am the legal parent/guardian of the child listed below, I have read the above release, and I fully understand its contents.

Student's Name *(please print)* : _____

Parent/Guardian Signature : _____

Date : ☐☐ / ☐☐ / ☐☐☐☐

Contact Us:

10560 N Ambassador Dr, Ste. 210, Kansas City, MO 64153

1-855-454-3744

www.kid-sight.org

assistance@kid-sight.org

FAMILY FOCUS EYECARE