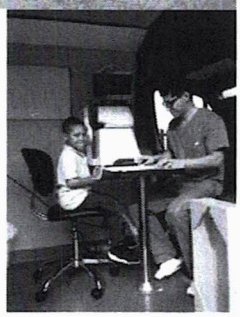
Vision To Learn
Focus on the Future

Dear Parent or Caregiver,

A vision screening was given at your child's school/community program, indicating that your child may have difficulty seeing. Vision To Learn, a mobile eye clinic that provides free eye exams and free eyeglasses, is coming to your school/community program in the next few weeks and can help your child's vision. Since 80% of children's learning is obtained through vision, when children can see well they can be more successful at school. Here's how the program works:

1. Send your signed consent form back to school/organization, giving Vision To Learn permission to examine your child's eyes.
2. The Vision To Learn mobile clinic will arrive at the school/organization and a representative will take your child to our bus to be examined by an Optometrist and Optician.
3. If needed, the doctor will prescribe the correct eyeglasses lens for your child.
4. Children choose frames they like and get fitted for glasses.
5. In 2-3 weeks, eye care professionals will return to the school/organization to deliver your child's eyeglasses and make sure they fit correctly.



"The day I got glasses I realized that I did need glasses because everything was all blurry. I had trouble learning. And then the truck came and changed my life because I started to get vision."

If you have questions or need further information, please contact your school nurse.

You can contact Vision To Learn at (302)220-4820 or delaware@visiontolearn.org,

or visit our website at www.VisionToLearn.org.

Rev 06/2016

MOBILE VISION SERVICES
CONSENT AND RELEASE FORM

Vision To Learn
Focus on the Future

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.

However, if your child is covered by Medicaid and is a member of Highmark Blue Cross Blue Shield Delaware or UnitedHealthCare, then your benefits will be used to cover the services offered to your child. You will not be billed for services provided by Vision To Learn.

Vision To Learn sometimes collects images and/or academic information about children it serves in order to publicize and evaluate itsprograms. 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 orguardian. You agree that Vision To Learn may collect your child's academic, behavioral, attendance, and demographic data (collectively called "Data") from your school or youth service organization. You agree that you are waiving any and all claims against your school and Vision To Learn that may arise from your participation in the program or the use of the Recordings or the Data.

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 / Year

Child's Gender (please check one): ☐MALE ☐FEMALE

Parent/ Guardian First Name: Parent/ Guardian Last Name:

CONTACT INFORMATION:

Street Address: Unit/ Apt:	City:	State:	Zip:
Phone Number:	Emergency Phone Number:	Email:	

SCHOOL INFORMATION:

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

INSURANCE INFORMATION:

OPTIONAL:

☐Child Has Medicaid

Provider (circle one): Highmark United	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 my child is allowed one eye exam, one pair of frames and the dispensing of one pair of glasses every 12 months as a member of Highmark Blue Cross Blue Shield Delaware or UnitedHealthCare, unless medically necessary. I understand that receiving vision services through Vision To Learn's mobile vision clinic will disqualify me from accessing non mobile services for vision care for 12 months from the date of exam. I also authorize the release of any medical or related information required for Highmark Blue Cross Blue Shield Delaware, UnitedHealthCare or the provider to submit a claim and receive payment from Medicaid, where applicable, for vision services provided to my child. 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: _____

100 West 10th Street, Suite 106, Wilmington, DE 19801 (302) 307-2761 Fax: (302) 397-2722 VisionToLearn.org