

APPLICATION FOR CHILD EYE EXAM & EYEWEAR

Your completed form will be reviewed to determine your eligibility. If you are qualified, you will be contacted.

You must answer all information and questions. Verification may be requested.

| | |
|---|----------|
| Parent's Name & Address: | |
| Home Phone: | |
| Does this child have private or government insurance, Medicaid or Medicare (OHP) that covers eye exams? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is anyone in your household currently working at least part-time? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| What is the total number of people in your household living with you, including yourself? | |
| What was your household's approximate gross income (before taxes and deductions) including income from other sources such as alimony and child support? Please enter whole dollar amount only. Last month: \$ _____ or Last Year: \$ _____ | |
| School Name & Address: | Contact: |
| | Title: |
| | Phone: |
| | County: |

Child's Information:

| First Name | Last Name | Date of Birth | Social Security # <small>(Child's or Parent's)</small> | Date of last eye exam |
|------------|-----------|---------------|--|-----------------------|
| | | | | |

Please list any other circumstances that limit your access to vision care (i.e. transportation).

Please return this completed form to:

Oregon Foundation for Vision Awareness
 4404 SE King Rd
 Milwaukie, OR 97222
 503-654-5036

Or to your School Nurse or Head Start Director