EYE THRIVE

FREE eye EXAM and GLASSES for your child!

Eye Thrive is proud to conduct on-site vision screenings and operate a Mobile Vision Clinic that provides eye exams and prescription glasses to children throughout our community. This free health service is authorized by the St. Louis County Library.

If needed, I want my child to get an eye exam and glasses at NO COST.

Child's Name _____ Date of Birth _____ Gender M F

Street Address_____

City_____ State _____ Zip Code _____

Phone Number _____ School _____Grade_____

Child's Ethnicity African American Asian Biracial Caucasian Eastern European
Hispanic Latino Native American Other _____

Is your child enrolled in Medicaid? (circle one) NO YES If yes, my child's Medicaid ID is: _____

Is your child enrolled in Free or Reduced Lunch? (circle one) NO YES

Your signature below authorizes our licensed optometrist and staff to conduct an eye examination (with drops if needed) and prescribe and dispense eyewear (if needed). You are also authorizing full disclosure of the results of your child's eye examination. This information may be shared with the following individuals: yourself, your child's school nurse, and any specialist we may refer your child to for follow-up and continuity of care. You are also giving permission to verify Medicaid eligibility and, if applicable, bill Medicaid for the eye examination only.

I understand that, because an eye exam involves close physical proximity, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved in my child receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/organization from any claims related thereto.

Parent/Guardian SIGNATURE _____

Parent/Guardian Printed Name _____

Your signature below allows your child to be photographed or filmed solely for the promotion of Eye Thrive.

Parent/Guardian SIGNATURE _____

Health History:

Has your child had a fever in the last 24 hours of 100.4 degrees F or higher?	Yes No
Does your child currently have a sore throat, fever, fatigue, loss of smell or respiratory symptoms?	Yes No
Has your child tested positive for COVID-19 in the last 14 days?	Yes No
Has your child been in contact with anyone that has tested positive for COVID-19 in the last 14 days?	Yes No
Has your child ever received an eye exam?	Yes No
Has your child ever been prescribed glasses? How long ago?	Yes No
Does your child wear glasses now?	Yes No
Does your child complain of blurry vision?	Yes No
Has your child ever injured or had surgeries on his/her eyes?	Yes No
Please list any medications your child is currently taking.	_____
Please list any food or medication allergies your child has.	_____
Please list any illnesses your child has been diagnosed with.	_____
Please list any family history of eye disease.	_____