EYE THRIVE

FREE eye EXAM and GLASSES for your child!

Eye Thrive is proud to operate a Mobile Vision Clinic that provides eye exams and prescription glasses to children throughout our community at no cost. This free health service is authorized by St. Louis County Library.

Child's FIRST Name:_____ **Date of Birth**:_____

Child's LAST Name:_____

Gender: Male Female Other Prefer Not to Say **Ethnicity**: African-American Asian Caucasian Hispanic Multiple Races Native American Other_____

Child's School:_____ **District**:_____ **Grade**:_____

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

Parent Cell Phone:_____ **Parent Email Address**:_____

Home Street Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Your signature below certifies that you are the parent/legal guardian of the minor listed and 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:_____ **Date**:_____

Parent/Guardian Printed Name:_____ **Relationship to Patient**:_____

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 ever received an eye exam?	Yes	No	If yes, was it from Eye Thrive?	Yes	No
Has your child ever been prescribed glasses?	Yes	No	If yes, how long ago?	_____	
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			
Does your child have diabetes?	Yes	No			

Please list any medications your child is currently taking. _____

Please list any food or medication allergies your child has. _____

Please list any medical conditions your child has been diagnosed with. _____

Please list any family history of eye disease. _____