LEVEL UP KIDS

ICARE4KIDS

FREE VISION CARE

MOBILE VISION PROGRAM
5416 NE Antioch Rd • Kansas City, MO 64119 • 816.413.9009

Date:_____

CHILD INFORMATION

Legal Full Name: _____ Sex (circle): Male / Female DOB: _____

School: _____ District: _____

Address (street, city, state): _____ Zip: _____

Language Spoken at Home: _____ Race (circle which apply): Caucasian American Indian African American Asian Hispanic Other: _____

INSURANCE INFORMATION (please check one)

- ☐ **Medicaid** Child's Medicaid #: _____
- ☐ **Private Insurance**
- ☐ **Uninsured**

PARENT / GUARDIAN INFORMATION

Parent / Guardian Name: _____ Relationship to Child: _____

Parent / Guardian Date of Birth: _____

Address (if different from child): _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

MEDICAL / VISION HISTORY

Does your child wear glasses? YES / NO **Does your child wear contacts? YES / NO**

Has your child ever seen an eye doctor before? □ Yes □ No If yes, when? _____

Please check any past or present conditions: □ Uses eye medications/ointments □ Lazy eye □ Eye Surgery □ Diabetes

□ other: _____

CHECK any of the following that your child is ALLERGIC to or has had an adverse reaction to:

□ Penicillin □ Sulfa □ Latex Other: _____

Is your child taking medications? □ Yes □ No If yes, please list medications and reason for use: _____

_____

Dilated Eye Exam: A dilated eye examination requires your child to receive eye drops to dilate their pupils. This allows the eye doctor to obtain the most accurate glasses prescription and assess the overall health inside of the eye. Most children will have mild blurry vision and sensitivity for approximately 4 hours. In very young children or patients with lighter colored eyes, the dilation can last longer.

□ Please do **NOT** dilate, even if it is needed to evaluate eye health or provide an accurate glasses prescription.

We will NOT be able to see your child unless BOTH SIDES of the form are completed and all 3 signature lines are SIGNED

TURN OVER →

MOBILE VISION PROGRAM – INCOME GUIDELINES TO RECEIVE SERVICES
200% of Federal Poverty Level Guidelines

***You **MUST** provide your household income to be eligible for free vision care and glasses from LevelUp Kids Inc.*

Names of ALL household members	*Gross Monthly Earnings (before deductions)*	*Monthly welfare, child support and alimony*	*Monthly payments from pensions, retirement, Social Security*	*Any other monthly income*
1.	$	$	$	$
2.	$	$	$	$
3.	$	$	$	$
4.	$	$	$	$
5.	$	$	$	$

Signature of Adult Household Member **Date**

I voluntarily consent to the rendering of Optometric routine care, diagnostic procedures, and medical advice, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I also authorize the release of information for any applicable insurance coverage.

Signature of Parent / Legal Guardian **Date**

I certify that all of the above information is true and correct and current. I understand that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal Laws.
We are required by law to give you a copy of the HIPPA notice and to obtain your written acknowledgement that you have received a copy of this notice. HIPPA Notice: Can be viewed online at www.LevelupkidsInc.org/patientinfo

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature Parent / Legal Guardian **Date**

PHOTO RELEASE (Do not sign if you wish to decline)
I authorize LevelUp Kids, Inc. to take photographs of my child for educational publications or lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.). I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature Parent / Legal Guardian **Date**

For more information about our services and organization,
please visit www.levelupkidsinc.org
or call our office at 816.413.900