

FREE VISION CARE

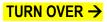
MOBILE VISION PROGRAM

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	Id wear contacts? YES / NO	
Has your child ever seen an eye doctor before? \Box Yes \Box No If yes,	when?	
Please check any past or present conditions: □ Uses eye medications/	ointments 🛛 🗆 Lazy eye 🗆 Eye S	Gurgery
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? \Box Yes \Box No If yes, please list medic	ations and reason for use:	

<u>Dilated Eye Exam</u>: 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.

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



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

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

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

Date

Date