Mobile Clinic Application for Lions Eyeglasses
I request help from the Lions Clubs of District 2-X1

To obtain a vision examination and glasses, if required, for my child
(All blanks to double lines MUST be filled out to be eligible)

Student's Name: ____________________________________Social Security Number: ___________________

Address: _______________________________________ Apt. #: ____ City: ______________ Zip: __________

Home Phone: _____________________ Date of Birth: __________________ Grade: _____

Qualification Guidelines:

1. The recipient, student or adult, must not have Insurance/Medicaid that will pay for his/her glasses.
2. The recipient's family income must fall below poverty level (3) three times.

Total Number of Household Members: _______.

Total Yearly Household Income: $ _____________.

I swear or affirm that the above information is true, that we meet the above conditions and that me, or my child does qualify for the free exam and glasses. Additionally, I am hereby authorizing **FULL** disclosure of the results of my or my child's vision examination, provided by the Lions Sight & Tissue Foundation and/or its partners. This information may be shared only with the following individuals: **his/her School Nurse, ESSILOR or another LSTF program partner.** I understand that I may, at any time revoke this authorization in writing, however, by doing so I understand that I will forfeit any services provided by the Lions Sight & Tissue Foundation and/or its partners. I understand if an unauthorized disclosure is made, I may file a formal complaint with the United States Department of Health and Human Services.

____Parent/Guardian Signature

____ Printed Name

FOR SCHOOL NURSE USE ONLY (REQUIRED)

Failed Vision Screening TWICE on these Dates: 1st ___________________ 2nd ____________________

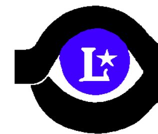
Symptoms or Complaints: ____

School Nurse: ______________________________Tax Exempt No.: _______________ Phone: ____________

School: ____ School District: ___________________________

School Address: ______________________________ City: ________________________Zip: _____________

Signature: ____



Aplicacion para Anteojos de la Clinica Mobil
Yo Solicito ayuda del Club de Lions del Districto 2-X1

Para obtener una examen de la vista y anteojos, para mi nino/a
(favor de llenar todas las lineas)

Nombre de estudiante: _______________________________________# de Seguro Social:____________________

Domicilio: ____ # de Apt: ___________

Ciudad: __________________________ Zona Postal _______________

de telefono: _____________________ fecha de nacimiento: _______ Ano Escolar: _______

Guia de Calificaciones:

3. El recibidor (estudiante o adulto) no debe de tener aseguranza o Medicaid que puede pagar sus anteojos.
4. El salario del recibidor debe de estar debajo del nivel de ingreso (3 veces).

Total de miembros de la casa ___________

Ingreso total del ano: $________________

Yo afirmo que la informacion es verdad, que nosotros cumplimos con las condiciones y que yo o mi nino/a calificamos para tener anteojos o examenes gratis. Tambien yo autorizo revelacion total del examen proveido por Lions Sight & Tissue Foundation. Esta informacion puede ser compartida solamente con la enfermera de la escuela. **ESSILOR or another LSTF program partner,** Yo entiendo que yo puedo rechazar esta autorizacion en escrito, pero con hacer eso, yo entiendo que yo pierdo todos los derechos de servicios proveidos por el Club de Lions Sight & Tissue Foundation y sus patrocinadores. Yo entiendo que si una revelacion no es autorizada, Yo puedo presentar una demanda con los Servicios de Salud y Humanos de los Estadso Unidos.

____Guardiante/Padre firma

____ Letra de molde

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Symptoms or Complaints: ____

School Nurse: _______________________________Tax Exempt No.: _________________ Phone: _____________

School: ____ School District: _________________________

School Address: __________________________________ City: _______________________ Zip: _____________

Signature: ____