Student's Name ______________________

Address: ____________________________

____

Date of birth: _____/__________/________

School: ____________________________

Parent/guardian: _____________________

Phone: ____________________________

Parent/guardian permission:

I hereby authorize Dr. Jon Dooley to provide an eye examination and any services or materials deemed necessary by the doctor as provided in the Vison Possible program.

____

Signature of parent or guardian

Date: _______/_______/__________

Optional: please provide email address or cell phone # below if you would like to receive a brief report of the results of your child's eye exam by email or text.

____

List any significant health problems:

____

List any daily prescription medicines:

____

____

List any medical allergies below:

____

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