Mobile Vision Care Clinic

ST. JAMES ASSINIBOIA SCHOOL DIVISION

EYE EXAMINATION CONSENT

Please Print Clearly

A. STUDENT INFORMATION:

Last Name	First Name		Name of School
Date of Birth (MM/DD/YYYY) ______ / ______ / ______________	**Gender**	**Grade**	**Classroom #**
Address – AS SHOWN ON MB HEALTH CARD (Street address, City, Postal Code)			

Do you want your child to participate in the Mobile Vision Care Clinic program?

☐ Yes (Please complete and return form to the school)

☐ No, ______________________________ (Please complete Section A and return form to the school)

(Parent/Guardian Signature)

B. STUDENT MEDICAL INFORMATION:

Manitoba Health Number (6 Digits)	PHIN Number (9 Digits)

***** Has your child seen an optometrist this calendar year? *****

☐ No ☐ Yes, Date of Eye Exam: ______________________________________

Eye Health History (Conditions, Injuries, Surgeries, etc.)

Is the student currently a patient of an eye specialist? No Yes , ________________________________

____

____

Medical Conditions, Current Medications, Allergies

____

____

Family Medical History (Eye Conditions, Medical Conditions, i.e. Diabetes, Glaucoma, etc.)

____

____

(Over →)

C. COVERAGE FOR PRESCRIPTION EYEGLASSES:

In order to ensure timely provision of prescription eyeglasses (if required), please provide the following information:

Do you have insurance? ☐ **No** (Please go to Part D) ☐ **Yes** (Please complete the appropriate section(s) below)

Private Insurance Coverage *(if applicable)*	
Insurance Company Name	
Contract/Policy Number	**ID Number/Group Number**
Insured Member Name (Parent/Guardian of Student) ______________________ **First** **Last**	**Insured Member's Date of Birth (Parent/Guardian)** _______ / _______ / _______________ **MM DD YYYY**

Treaty or Status Number (Non-Insured Health Benefits) ***(if applicable)*** **(10 Digits)**	**Employment and Income Assistance Number (Social Allowances Health Services Card)** ***(if applicable)*** **(6 Digits)**

D. PERMISSION TO SHARE FINDINGS:

With other Health Care Providers, as deemed appropriate (Family Doctor/Pediatrician/Other)	☐ **Yes**	☐ **No**
With Louis Riel School Division Staff (Sharing information with LRSD is for the purpose of providing the highest level of support for each student to reach their full academic	☐ **Yes**	☐ **No**

E. CONSENT:

Please sign below to provide consent for your child to receive a comprehensive eye examination, including dilation if necessary, by a fully licensed and accredited "MOBILE VISION CARE CLINIC INC." Doctor of Optometry, and be provided with prescription eyeglasses, if required. **

Date	**Parent/Guardian Daytime Phone Number**	
Parent/Guardian Name (Please Print)	**Parent/Guardian Signature**	**Relation to Student**
Student Name – *(if over 18 years of age ONLY)*	**Student Signature –** *(if over 18 years of age ONLY)*	

*** ALL OPTOMETRIC SERVICES HEREIN WILL BE PROVIDED BY A FULLY LICENSED AND ACCREDITED "MOBILE VISION CARE CLINIC INC." DOCTOR OF OPTOMETRY.

*** ALL PRESCRIPTION EYEGLASSES PROVIDED HEREIN WILL BE FIT AND DISPENSED UNDER THE GUIDANCE OF A FULLY LICENSED AND ACCREDITED "MOBILE VISION CARE CLINIC INC." OPTICIAN.