



EYE EXAMINATION WAIVER FORM

Please print:

Student's Name: Last			First	Middle	Birth Date: (Month/Day/Year) / /
Address: Street		City		ZIP Code	Telephone:
Name of School:			Grade Level:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:			Address (of parent/guardian):		

I am unable to obtain the required vision examination because:

- My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All KIDS).
- My child is enrolled in Medicaid/All KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community that is able to see the child and accepts Medicaid/All KIDS.
- My child does not have any type of medical or vision/eye care insurance coverage, and there are no low-cost vision/eye clinics in our community that will see my child.

Signature _____

Date _____