SIGHTFEST PERMISSION FORM

ATTENTION PARENTS!

According to a vision screening, your child may have trouble seeing clearly and should see an eye doctor.

IF:

- ✓ Your child does **NOT have medical insurance (including Medicaid)** that covers a vision exam and/or glasses.
- ✓ Your child is eligible for the reduced or free lunch program at school.

THEN:

- ✓ Please fill out this form and bring it back to school by **DECEMBER 18.**

On **JANUARY 26, 2024**, your child's school will transport he/she to **Murray City School District Office (5102 S Commerce Dr.)** and will receive a **FREE** eye exam. They will arrive back to school before the end of the day. Students prescribed glasses will be transported to have them dispensed or will be delivered to them at school in 4-6 weeks.

FOR NURSE/PROGRAM ADMINISTRATOR/SCREENER ONLY *(REQUIRED)*

Visual Acuity Right: _____

Left: _____

Both: _____

Date Tested _____/_____/_____

Nurse/Administrator Name:

_____

If you have any questions, please contact Friends for Sight at (801) 524-2020

Student Name _____
First MI Last

Home Address _____

School Name _____ Age ___ Birthdate ____/____/____Gender: M / F / __

HEALTH HISTORY:

Does your child or any immediate family member (parent, grandparent and sibling) have any of the following:

EYE DISEASE Yes ☐ Relationship:_____ No ☐
List: _____
_____

Does your child have any known ALLERGIES? Yes ☐, please list: _____
No ☐

Is your child currently taking any MEDICATION? Yes ☐, please list: _____
No ☐

Has your child ever worn glasses? Yes ☐ No ☐

Does your child have insurance? Yes ☐, Provider:_____ No ☐

*If insured what is the reason insurance will not cover: (i.e. Exhausted benefits, no transportation, etc.)

_____

Please list any known problems or symptoms your child has with his/her vision or eye health:

_____

_____

I give my permission for my son/daughter to receive a free eye exam and glasses at SIGHTFEST.

I give my permission for my child to be transported by the school district in a bus/motor vehicle to and from the SIGHTFEST event and glasses dispense. I understand that my child is expected to follow all applicable laws regarding riding in a motor vehicle and is expected to follow the directions provided by the driver and/or other adult volunteers.

Eye drops may be used during the exam to enlarge the pupil allowing the doctor to see inside of the eye. These drops will not harm the eye/eyesight. The pupil will be larger than normal, but will return to its normal size within a few hours up to a day. During this period, the patient may experience light sensitivity and blurry vision/difficulty reading.

I hereby release, waive, and discharge the organization, officers, directors, employees, representatives, volunteers, agents, affiliates, and/or assigns of the independent optometrist(s) and Ophthalmologist(s) who perform the eye exam, of any cosponsoring agency, and of Friends for Sight, from any and all claims, damages, demands, loss and, or, liability resulting from or arising out of this event.

I give my consent that this event may be photographed or filmed for use in internal communications and for advertising, promotion and publicity relating to SIGHTFEST and its sponsors.

_____ _____/_____/_____
Parent/Guardian Signature Date

_____ (_____)_____
Parent/Guardian Printed Name Phone *(required)*