CASE # ____ - _____

REQUEST FOR LIONS CLUB ASSISTANCE FOR EYEGLASSES

STUDENT/ PATENT NAME: FIRST _____ MI ____ LAST _____

SOCIAL SECRITY OR ECISD STUDENT NO: _____-_____- _____ PHONE NO.:_____

ADDRESS: _____ SPACE OR APT #: _____ ZIP _____

DATE OF BIRTH ____-____-____ NUMBER IN FAMILY _____

AGE _____ GRADE _____ SCHOOL _____

***** PLEASE NOTE IF THERE IS ONLY ONE PARENT OR GUARDIAN *****

MOTHER:_____ ADDRESS _____
Employer: _____ Monthly Income $_____

FATHER: _____ ADDRESS: _____
Employer: _____ Monthly Income $_____

FAMILY MONTHLY INCOME $_____ (circle one)

MONTHLY HOUSEHOLD EXPENSES $_____

HAS THIS PATIENT OR OTHER FAMILY MEMBER RECEIVED LIONS CLUB ASSISTANCE BEFORE? [ ] YES [ ] NO

Other Comments from Parent:_____
_____

_____ _____
PARENT OR GUARDIANS SIGNATURE **DATE**

NOTICE: THE EYEGLASSES SELECTED FOR THE LIONS CLUB EYEGLASS PROGRAM MUST BE FROM A PRESELECTED GROUP OF EYEGLASSES. **ANY SUBSTUTION OF FRAMES OR LENSES OUTSIDE THIS PRE-SELECTED GROUP WILL BE AT THE TOTAL EXPENSE OF THE PATIENT AND WILL VOID THIS LIONS CLUB APPROVAL FOR ASSISTANCE.**

TO BE FILLED OUT BY THE SCHOOL NURSE

SERVICES REQUESTED BY SCHOOL NURSE: [ ] NEW EYE EXAM [ ] REPAIR EYEGLASSES
[ ] NEW GLASSES [ ] REPLACE LOST GLASSES

1st vision test: by: _____ Date _____
2nd vision test: by: _____ Date _____

Application reviewed and recommended for an eye exam by School Nurse:_____
School Nurses – Print Name

_____ _____
School Nurse Signature Date