



UNITED INDEPENDENT SCHOOL DISTRICT
SCHOOL HEALTH PROGRAM
APPLICATION FOR EYE CARE

School _____ Grade _____ Teacher _____

Student's Name _____ DOB _____

Father _____ -,Mother _____

Guardian _____

Home Address _____ Phone _____

Employer of Father/Guardian _____

Employer of Mother _____

Total Household Income (Father) _____ (Mother) _____

How many children at home _____ Other _____

Do you get Government Assistance? (Yes) _____ (No) _____

Do you have Medicaid? _____

Outstanding Loans (Yes) _____ (No) _____ Other _____

Medical/Dental Bills (Yes) _____ (No) _____ Other _____

Have you ever received assistance in obtaining eye exam or eye glasses from any school or civic organization within the last two years?

YES _____ NO _____

Parent/Guardian Signature _____ Date _____

Nurse Recommendation Yes _____ No _____

Nurse Signature

Approved By: Linda D. Flores, RN , MSN
Director School Health Program

Approved: Yes _____ No _____