Please Print Clearly

Mobile Vision Care Clinic

WINNIPEG SCHOOL DIVISION

EYE EXAMINATION CONSENT FORM

***** Has your child seen an optometrist this calendar year? (January - December 2018)*****

No ☐ Yes ☐, Date of Eye Exam: _____

STUDENT INFORMATION:

Last Name	First Name		Name of School
Date of Birth (MM/DD/YYYY) _____ / _____ / _____	**Gender**	**Grade**	**Classroom #**
Manitoba Health Number (6 Digits) ☐☐☐☐☐☐	**PHIN Number (9 Digits)** ☐☐☐☐☐☐☐☐☐		
Address – AS SHOWN ON MB HEALTH CARD (Street address, City, Postal Code)			

STUDENT MEDICAL HISTORY:

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

Is the student currently a patient of an eye specialist? **No** ☐ **Yes** ☐ , _____
Name of Doctor

_____

_____

Medical Conditions, Current Medications, Allergies

_____

_____

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

_____

_____

(Over →)

COVERAGE FOR PRESCRIPTION EYEGLASSES:

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

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)**

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**

PERMISSION TO SHARE FINDINGS:

With other Health Care Providers, as deemed appropriate **(Family Doctor/Pediatrician/Other)**	**Yes** ☐	**No** ☐
With Winnipeg School Division Staff	**Yes** ☐	**No** ☐

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 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.

** CONSENT COVERS AN ANNUAL EXAMINATION FOR YOUR CHILD WHILE A STUDENT IN THE WINNIPEG SCHOOL DIVISION.