

Eye Examination Waiver Form

Ple	ease print:							
Student Name(Last)						Birth Date		
	(Last)	(Fi	rst)	(Middle Initial)	_	(Mont	h/Day/Year)	
Scl	hool Name			Grade Level	_ Gender:	■ Male	☐ Female	
Ad	dress							
	(Number)	(Street)		(City)		(ZIP Co	ode)	
Ph	one(Area Code)							
Pa	rent or Guardian	(Last)		(Firs	+ \			
Λ -1	description Occasion	` '		(1 115	ι)			
Aa	dress of Parent or Guardian _	(Number)	(Street)	(City	′)	(Z	(IP Code)	
l aı	m unable to obtain the requi	red vision examinatior	n because:					
	My child is enrolled in medical examinations or an optometric ALL KIDS. My child does not have any ty ALL KIDS, there are no low-content means and do not have Other undue burden or a lack	st in the community who pe of medical or vision/e ost vision/eye clinics in sufficient income to pro	o is able to ex ye care covera our communit ovide my child	amine my child and a age, my child does no by that will see my ch with an eye examina	accepts med t qualify for ild, and I ha ation.	dical assi medical a ve exhau	stance/ assistance/ usted all	
Sig	gnature			Date				
	(Source	ce: Added at 32 III. Re	eg	, effective		_)		