OCULAR SERVICES MANAGEMENT

Dear Parents,

The Lakewood City Schools are partnering with Ocular Services Management to offer comprehensive eye health and vision examinations at all Lakewood city schools. Please complete the following information and the enclosed packet if you would like your child to participate in this program.

Student Name_____ Birth Date_____ Sex_____ Grade_____

Parent or Guardian_____ Phone_____

Address_____

email_____School_____

Insurance Information

Medical Insurance Name_____ ID#_____

Vision Insurance Name_____ID#_____

Subscribers Name_____DOB_____SS#_____

Kindly check all boxes:

○ I authorize Ocular Services Management to perform a comprehensive eye health and vision examination on my child. I understand that my insurance will be billed and that I will be responsible for any amount not covered by my insurance company.

○ If my child needs glasses I authorize Ocular Services Management to select a frame with my child. In the event that my insurance does not cover glasses I will be contacted by Ocular Services Management and payment is required before the order will be placed.

○ I authorize *Ocular Services Management* to share a copy of my child's vision examination report with appropriate school official(s).

Signature_____Relationship to Child_____

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