VOUCHER #: ______________
DATE ISSUED: ______________

TO BE FILLED OUT BY SCHOOL NURSE (please print legibly)

Student's Name: ____Sex (Circle): M F D.O.B.____________

Address: ___________________________________ City: ______________________ Zip Code: _________

Home Phone #: _________________________________ Cell #: __________________________________

School Name: ____________________________________ School District: _________________________

School Nurse's Name: ______________________________ Phone #: _____________________________

__ It has been verified from a vision screening that the student needs an eye exam.
__ It has been verified that student is not covered by Medicaid or insurance. Verification Code: ______________
__ I have contacted and sent this completed voucher to the student's parent/guardian for signature.

The phone number to activate this voucher is 575-525-5631 and fax number 575-524-1699 or scan to email nmlionskidsight@gmail.com for submission of completed form

_____________________________ _______________________________________ _____________
School Nurse's Signature Email Address Date

Parents/Guardians

1. Once this voucher form is complete and returned to the school Nurse she/he will send us the form and request the eye care providers contact information from the NM Lions Operation KidSight Program Manager. This information will be given to you in writing to call and schedule an appointment for your child.

2. If the eye exam results show the need for glasses, NM Lions Operation KidSight/Save Our Children's Sight Fund will provide the medically necessary eyeglasses for your child which will include a fashion frame and a basic pair of polycarbonate lenses. Any options, upgrades, add-on, or treatments will not be covered.

3. *Note that this voucher is non-transferable and only valid for the person whose name is written above. Copies or Facsimiles cannot be combined with any other offer or promotion.*

4. Please read and sign the agreement below:

By signing this form you understand and consent to the following:

__ I, the parent or legal guardian, acknowledge that my child is **not** covered by Medicaid or private insurance that would cover the cost of an eye exam and treatment (glasses) if needed.
Initial here if covered by Medicaid but funds are unavailable____ Medicaid Number: _______________________

__ I, the parent or legal guardian, give my permission for the attending eye professional and treatment provider to furnish the NM Lions Operation KidSight Central Office with the eye exam results to facilitate the payment for the eye exam and treatment. I understand all HIPPA privacy regulations will be followed.

__ I understand this voucher expires 30 days from the date of issued.

__________________________ ____ _____________
Print Parent/Guardian Name Parent's/Guardian's Signature Date

NMLOKS/NMDOH Save Our Children's Sight Fund Voucher
1501 N. Solano Drive, Las Cruces, NM 88001

VOUCHER #: ________________
DATE ISSUED: ________________

TO BE FILLED OUT BY SCHOOL NURSE (please print legibly)

Student's Name: ____Sex (Select): M F D.O.B.______________

Address: ____ City: _________________________ Zip Code: __________

Home Phone #: ______________________________________ Cell #: _______________________________________

School Name: ____ School District: _____________________________

School Nurse's Name: ___________________________________ Phone #: __________________________________

__ It has been verified from a vision screening that the student needs an eye exam.

__ It has been verified that student is not covered by Medicaid or insurance. Verification Code: _________________

__ I have contacted and sent this completed voucher to the student's parent/guardian for signature.

The phone number to activate this voucher is 575-525-5631 and fax number 575-524-1699 or scan to email nmlionskidsight@gmail.com for submission of completed form

_________________________________ ____ ______________

School Nurse's Signature Email Address Date

Parents/Guardians

1. Once this voucher form is complete and returned to the school Nurse she/he will send us the form and request the eye care providers contact information from the NM Lions Operation KidSight Program Manager. This information will be given to you in writing to call and schedule an appointment for your child.

2. If the eye exam results show the need for glasses, NM Lions Operation KidSight/Save Our Children's Sight Fund will provide the medically necessary eyeglasses for your child which will include a fashion frame and a basic pair of polycarbonate lenses. Any options, upgrades, add-on, or treatments will not be covered.

3. *Note that this voucher is non-transferable and only valid for the person whose name is written above. Copies or Facsimiles cannot be combined with any other offer or promotion.*

4. Please read and sign the agreement below:

By signing this form you understand and consent to the following:

__ I, the parent or legal guardian, acknowledge that my child is **not** covered by Medicaid or private insurance that would cover the cost of an eye exam and treatment (glasses) if needed.
Initial here if covered by Medicaid but funds are unavailable____ Medicaid Number: __________________________

__ I, the parent or legal guardian, give my permission for the attending eye professional and treatment provider to furnish the NM Lions Operation KidSight Central Office with the eye exam results to facilitate the payment for the eye exam and treatment. I understand all HIPPA privacy regulations will be followed.

__ I understand this voucher expires 30 days from the date of issued.

_____________________________ ____ ______________

Print Parent/Guardian Name Parent/Guardian's Signature Date

VOUCHER #: ________________
DATE ISSUED: _______________

TO BE FILLED OUT BY SCHOOL NURSE (please print legibly)

Student's Name: ____Sex (Circle): M F D.O.B.______________

Address: ____ City: __________________________ Zip Code: __________

Home Phone #: _______________________________________ Cell #: ______________________________________

School Name: ____ School District: ______________________________

School Nurse's Name: ___________________________________ Phone #: ___________________________________

__ It has been verified from a vision screening that the student needs an eye exam.
__ It has been verified that student is not covered by Medicaid or insurance. Verification Code: _________________
__ I have contacted and sent this completed voucher to the student's parent/guardian for signature.

The phone number to activate this voucher is 575-525-5631 and fax number 575-524-1699 or scan to email nmlionskidsight@gmail.com for submission of completed form

___________________________________ ____ _______________
School Nurse's Signature Email Address Date

Padres/Tutores

1) El/la enfermera de la escuela rellena esta forma que indica que su hijo necesita un examen completo de los ojos provisto de un optometrista u oftamólogo. El/la enfermera le da a Usted (padres/tutor) una lista de proveedores de cuidado ocular. **Usted necesita llamar** a una de esas oficinas para hacer una cita para un examen de los ojos para su hijo. Dile a la oficina que el examen estará pagado por NM Lions Operation KidSight.

2) Si el examen de optometrista u oftamólogo indica que necesita espejuelos el fondo de NM Operation KidSight/Operation Save Our Children's Sight paga por una montura de moda y también lentes básicos hecho de policarbonata (lo que usa para todos los niños bajo de 19 años). Cualquier mejora, como lentes transiciones o ahumados NO está incluído.

3) *Esta forma no se puede transferar o usar por otra persona sino cuyo nombre está escrito encima. Copias o fax no se puede combinar con otra oferta o promoción.*

4) Por favor, lea y firma el acuerdo abajo:

   ___ Yo, el padre o tutor legal, admito que mi hijo no está cubierto por Medicaid ni seguro privado que cubriría el precio de un examen ocular y el tratamiento (como espejuelos) si sea necesario.
   Firmar con las iniciales si tiene seguro pero ya lo usó para este año y no hay fondos en este momento.
   _____ Numero Medicaid: ____

   ___ Yo, el padre o tutor legal, doy permisión al/a la optometrista para dar los resultados del examen ocular a NM Lions Operation KidSight Central Office para facilitar el pago del examen y espejuelos. Entiendo que las regulaciones de la privacidad de HIPPA estará seguido.

   ___ **Entiendo que este cupón expira 30 días de la fecha emitido.**

____
Nombre o padre/tutor Firma de padre/tutor Fecha

VOUCHER #: ________________
DATE ISSUED: ________________

TO BE FILLED OUT BY SCHOOL NURSE (please print legibly)

Student's Name: ____ Sex (Select): M F D.O.B.________________

Address: ____ City: _________________________ Zip Code: ___________

Home Phone #: _______________________________________ Cell #: _______________________________________

School Name: ____ School District: _____________________________

School Nurse's Name: ___________________________________ Phone #: __________________________________

__ It has been verified from a vision screening that the student needs an eye exam.

__ It has been verified that student is not covered by Medicaid or insurance. Verification Code: _________________

__ I have contacted and sent this completed voucher to the student's parent/guardian for signature.

The phone number to activate this voucher is 575-525-5631 and fax number 575-524-1699 or scan to email nmlionskidsight@gmail.com for submission of completed form

________________________ ________________________ ____________

School Nurse's Signature Email Address Date

Padres/Tutores

1. El/la enfermera de la escuela rellena esta forma que indica que su hijo necesita un examen completo de los ojos provisto de un optometrista u oftamólogo. El/la enfermera le da a Usted (padres/tutor) una lista de proveedores de cuidado ocular. Usted necesita llamar a una de esas oficinas para hacer una cita para un examen de los ojos para su hijo. Dile a la oficina que el examen estará pagado por NM Lions Operation KidSight.
2. Si el examen de optometrista u oftamólogo indica que necesita espejuelos el fondo de NM Operation KidSight/ Operation Save Our Children's Sight paga por una montura de moda y también lentes básicos hecho de policarbonata (lo que usa para todos los niños bajo de 19 años). Cualquier mejora, como lentes transiciones o ahumados NO está incluído.
3. Esta forma no se puede transferar o usar por otra persona sino cuyo nombre está escrito encima. Copias o fax no se puede combinar con otra oferta o promoción.
4. Por favor, lea y firma el acuerdo abajo:

___ Yo, el padre o tutor legal, admito que mi hijo no está cubierto por Medicaid ni seguro privado que cubriría el precio de un examen ocular y el tratamiento (como espejuelos) si sea necesario.

Firmar con las iniciales si tiene seguro pero ya lo usó para este año y no hay fondos en este momento. _____

Numero Medicaid: ___________________________

___ Yo, el padre o tutor legal, doy permisión al/a la optometrista para dar los resultados del examen ocular a NM Lions Operation KidSight Central Office para facilitar el pago del examen y espejuelos. Entiendo que las regulaciones de la privacidad de HIPPA estará seguido.

___ Entiendo que este cupón expira 30 días de la fecha emitido..

________________________ ________________________ ____________

Print Parent/Guardian Name Parent/Guardian's Signature Date

NMLOKS/NMDOH Save Our Children's Sight Fund Voucher
1501 N. Solano Drive, Las Cruces, NM 88001