NEW MEXICO DEPARTMENT OF HEALTH

VOUCHER #: _____
DATE ISSUED: _____

TO BE FILLED OUT BY SCHOOL NURSE (please print)

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.
__ I have coordinated with the NM Lions Operation KidSight Central Office Program Manager
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 eye glasses 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. The voucher should be surrendered at the time of service. *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 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