GLASSES FOR KIDS CONSENT & VOUCHER

**Please bring this voucher to your appoinment**

Childs Name: ……………………………………………………………………

Date of Birth: ……………………………………………………………………

Home Address: …………………………………………………………………

School: ………………………………………………………………………….

Grade: ………………………………………………….......................................

Homeroom Teacher: ……………………………………………………………

Medicare Number: ………………………………………………………………

Reference Number (number of child on card): …………………………………

Medicare expiry date: …………………………………………………………..

I have read and understood the information attached and I would like my child to have a vision asssessment and hereby give consent for this and my child’s results to be forwarded to the ACE Foundation if glasses are required. This voucher is valid for twelve months from the date of issue.

Parent/Guardian Name:…………………………………………........................

Contact Number: ……………………………………………………………….

Signed: …………………………………………………………………………

Date: ……………………………………………………………………………

This ACE Foundation is proud to be assisting the children in the City of Casey.

All primary students are entitled to use this voucher **ONCE** at one of the listed optometrists. Vision testing is bulk billed and free glasses will be provided if they are required

**School stamp/signature required**