GLASSES FOR KIDS CONSENT & VOUCHER

Please bring this voucher to your appoinment

Students Name: …….

Date of Birth: ……

Home Address: ……

School: ……

Grade: …….....

Class Room Teacher: ……

Health Care Card: …….Expiry Date: …….

Pension Card: ……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.

You must have a **Valid Health Care Card or Pension Card** 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

School to confirm health/pension card ☐