Prevent Blindness Texas®

Sight for Students Program
APPLICATION FORM

Dear Parent/Guardian:

The *Sight for Students Program* is VSP Vision Care's national charity program that provides free eye exams and eyeglasses, when prescribed, to those children who qualify. In order for a child to qualify for the program, there are certain eligibility criteria that must be met. **TO APPLY FOR SERVICES, SUBMIT THIS COMPLETED APPLICATION TO YOUR NEAREST PREVENT BLINDNESS TEXAS OFFICE.** Please print or type legibly. Incomplete applications will not be processed. Please allow 2-3 weeks to process your application.

SECTION I: CHILD'S GENERAL INFORMATION (PLEASE PRINT OR TYPE)

Child's Name (First, Middle, Last):_____

Date of Birth (Month/Day/Year):_____/_____/_____Age:_____Sex: ☐ Male ☐ Female

Social Security Number:_____-_____-_____Race:_____

Mailing Address:_____Apt. #:_____

City:_____State:_____Zip:_____County:_____

Referring Agency/School:_____Contact Phone:_____

SECTION II: PARENT/GUARDIAN INFORMATION (PLEASE PRINT OR TYPE)

Parent/Guardian Name:_____Relation to Child:_____

Parent/Guardian Social Security Number (if applicable):_____-_____-_____

Phone Number:_____Email Address:_____

SECTION III: CHILD'S ELIGIBILITY AND BACKGROUND INFORMATION

Has the child failed a vision screening? ☐ Yes ☐ No

Is the child enrolled in Medicaid or CHIP? ☐ Yes ☐ No

Is the child enrolled in any other type of insurance, besides Medicaid or CHIP, which covers EYE EXAMS? ☐ Yes ☐ No

If yes, does the insurance cover EYEGLASSES? ☐ Yes ☐ No

Has the child used the *Sight for Students Program* during the last 12 months? ☐ Yes ☐ No

Is the child enrolled in the School Free and Reduced Lunch Program? ☐ Yes ☐ No

Total Annual Household Income: $_____Number of ALL Persons in the Household:_____

SECTION IV: PARENT/GUARDIAN AGREEMENT (PLEASE READ AND SIGN BELOW)

All information on this application is kept in the strictest confidence by Prevent Blindness Texas, Prevent Blindness America and agencies associated with our programs. By signing below, I attest that the above information is true and complete to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE:_____**DATE:**_____

PLEASE SUBMIT THIS COMPLETED APPLICATION VIA MAIL OR FAX TO YOUR NEAREST PBT OFFICE:

North Texas Region
3610 Fairmount St.
Dallas, TX 75219
Fax: (214) 521-5248

Southeast Texas Region
2202 Waugh Dr.
Houston, TX 77006
Fax: (713) 529-8310

Southwest Texas Region
1600 N.E. Loop 410, Suite 125
San Antonio, TX 78209
Fax: (210) 236-7671

FOR PREVENT BLINDNESS TEXAS OFFICE USE ONLY			
GC No.:	**GC Mailed To:** ☐ Parent ☐ Agency/School	**Date GC Mailed:**	**GC Mailed By:**