



Mobile Vision Care Clinic



WINNIPEG SCHOOL DIVISION

EYE EXAMINATION CONSENT FORM

***** Has your child seen an optometrist this calendar year? (January - December 2018)*****

No Yes , Date of Eye Exam: _____

STUDENT INFORMATION:

Last Name		First Name		Name of School	
Date of Birth (MM/DD/YYYY) ____ / ____ / ____		Gender	Grade	Classroom #	
Manitoba Health Number (6 Digits)			PHIN Number (9 Digits)		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Address – AS SHOWN ON MB HEALTH CARD (Street address, City, Postal Code)					

STUDENT MEDICAL HISTORY:

<p>Eye Health History (Conditions, Injuries, Surgeries, etc.)</p> <p>Is the student currently a patient of an eye specialist? No <input type="checkbox"/> Yes <input type="checkbox"/>, _____ <small>Name of Doctor</small></p> <p>_____</p> <p>_____</p>
<p>Medical Conditions, Current Medications, Allergies</p> <p>_____</p> <p>_____</p>
<p>Family Medical History (Eye Conditions, Medical Conditions, i.e. Diabetes, Glaucoma, etc.)</p> <p>_____</p> <p>_____</p>

