Educational Enrichment Foundation Focus on Vision Application

EEF USE ONLY

Application/Voucher Number:

____

Approval:

Approved By: ____________________

Date: ___________________________

PLEASE PRINT LEGIBLY. Complete ALL sections. Incomplete applications will not be considered. Students must meet eligibility requirements. Eligible students may utilize EEF's Focus on Vision program for one eye exam and/or one pair of eyeglasses per rolling 12-month period if funding is available.

Student's Name: *(Last)*____*(First)*____

Telephone Number:__________________ Date of Birth:_____________ Gender Identity: ☐Male ☐Female ☐________

Student's racial/ethnic identity: ☐Native American ☐Black/African American ☐Native Hawaiian/Pacific Islander

☐Asian ☐White ☐Hispanic/Latino ☐Multiracial ☐__________________

School Name: ___________________________________ Grade: _______________

Free/Reduced Meals: ☐Student qualifies for FREE Meals ☐Student qualifies for REDUCED Meals

☐Student does NOT qualify ☐UNSURE if student qualifies

Student is applying for: ☐Eye Exam and Glasses ☐Glasses only ☐Exam only

Does the student have insurance that covers vision care? ☐No ☐Yes If yes, explain:

____

Has the need for an eye exam/eyeglasses been substantiated by a school-administered vision test? ☐Yes ☐No

Describe any special circumstances EEF should consider when reviewing this application (*e.g. Teacher is concerned that student is struggling to see chalkboard*):

____

Parent/Guardian Authorization:

By signing below, I certify that the information provided on this application is true and correct to the best of my knowledge.

____ _______________________________________ ___________________

Parent/Guardian Name (print) Signature Date

TUSD employee authorizing/submitting this application:

Please submit the completed application to sam@eeftucson.org or 325-8579 (Fax). Direct questions to EEF by calling 325-8688.

Name (print):_________________________________Signature:___________________________________Date:__________________

School:____Title: ____

Email Address:_______________________________________Phone Number: ____

TUSD employee assigned to accompany the student to Nationwide (if different than above):

Transporting TUSD students to activities off school campus must comply with applicable TUSD policies.

Name (print):____Title:____

School:_______________________Phone Number:________________________Email Address:______________________________

Educational Enrichment Foundation
Solicitud de Enfoque en la Visión

EEF USE ONLY

Application/Voucher Number:

____

Approval:

Approved By: ____________________

Date: __________________________

POR FAVOR IMPRIMA DE MANERA LEGIBLE. No deje secciones en blanco. Las solicitudes incompletas no se tomarán en consideración. Los estudiantes deberán cumplir con todos los requisitos de elegibilidad. Los estudiantes elegibles pueden utilizar el programa Enfoque en la Visión de la EEF para un examen de la vista y/o un par de lentes por un período de 12 meses, si hay fondos disponibles.

Nombre del Estudiante: *(Apellido)*__________________________________ *(Nombre)*__________________________________

Número de Teléfono:_______________ Fecha de Nacimiento:_________ Identidad de Género: ☐Masculino ☐Femenino ☐________

Información racial/étnico(a) del estudiante: ☐Nativo Americano(a) ☐Afroamericano(a) ☐Nativo Hawaiano(a)/Polinesia

☐Asiático(a) ☐Blanco(a) ☐Hispano/Latino(a) ☐Multirracial ☐____________________

Nombre de la Escuela:____________________________________Grado:____________

El estudiante califica para asistencia de comida: (escoge uno) ☐GRATIS ☐REDUCIDO

☐NO califica ☐INCIERTO si califica

El estudiante está solicitando: ☐Examen de Ojos y Lentes ☐Solamente Lentes ☐Solamente Examen

¿Tiene el estudiante seguro que cubra el cuidado de la vista? ☐No ☐Sí Si es sí, explique:

____

¿Ha sido justificado un examen de la vista/adaptación de lentes por un examen de la vista administrado por la escuela? ☐Sí ☐No

Describa cualquier circunstancia especial que la EEF debiera considerar al repasar esta solicitud (*ej. Al maestro(a) le preocupa que el estudiante no pueda ver el pizarrón*):____

Firma del Padre/Tutor:

Al firmar abajo, yo certifico que la información proporcionada en esta solicitud es verdadera y correcta.

____ ____ ____________________

Nombre del Padre/Tutor (letra de molde) Firma Fecha

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School:____Title: ____

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Name (print):_______________________________________Title:____

School:_______________________Phone Number:________________________Email Address:______________________________