VISION4
Learning . Working . Living

Vision**4** Learning Program - Parent Consent Form

I, _____ give permission for my child

_____ of Class _____ to have a full eye examination

Onsite at _____

I have read the Parent information attached and understand the nature of the optometric service that will be conducted.

I understand that it will not be possible to allocate specific dates or times for each student's exam session as a result of the varying daily school schedules, activities, break times and other factors such as student absences.

I understand that I will be provided with an examination report outlining my child's results, and that the Vision4 clinician will endeavour to have these prepared in a timely manner following successful Bulk billing of the consultation.

By providing my child's personal and Medicare details and signing below, I consent to optometric assessment and appropriate Bulk billing through Medicare for the service provided.

I also acknowledge that I am aware and agree to the **Vision4** Privacy Policy which I can access through the **Vision4** website through the following link:

www.vision4.com.au

MEDICARE DETAILS

(Please ensure the details provided below are accurate, valid and legible to assist us with claiming appropriate Medicare benefits).

Name of student (as it appears on the card): _____

Medicare number: _____

Student's Reference number (found to the left of their name): _____

Expiry: _____

Student Address: _____

_____

_____

Parent/guardian mobile phone number: _____

Parent/guardian Email: _____

Parent/guardian Name: _____

Parent/guardian signature: _____