Cincinnati Children's Hospital Medical Center Outreach CVI Clinic

Hosted By:_____

Location: _____

Date: _____

I am interested in my daughter/son _____ participating in this free clinic through the Cincinnati Children's Hospital Medical Center. I understand that CCHMC is still in the process of finding a date and location for this clinic and that the date and location might change. I am willing to drive to the location of this clinic. I also give permission to release the following information to CCHMC's CVI outreach clinic team members.

Child's Name:_____

Child's Birthdate: _____

Address: _____

Phone Number(s):_____

Current Eye Doctor: _____

Caregiver's Names:_____

Caregiver's Signature: _____

Date: _____