Registration Form
Save Our Children's Sight Fund
Eye Care & Eyeglasses Referral Network

For New Mexico Students (Pre-K – up to 19 years of age)

Business Name: _____

Business Address: _____

Mailing Address: _____

City: _____State: _____ Zip Code: _____

Phone number: _____ Fax: _____

Email address: _____

Business Hours of Operation: _____

State Business License #: _____

Name(s) of Practitioner(s) who will see our referrals:

1. _____
2. _____
3. _____
4. _____

Services Provided:

Dilated Eye Exams: _____ Glasses: _____ Other: _____

Please sign and date below as acknowledgment and understanding of the process:

⇨ We agree to follow the guidelines set forth by the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) when conducting an eye examination on a student referred by the New Mexico Lions Operation Kidsight, Inc. (NMLOKS) program.

⇨ We agree to provide the eye examination results and treatment plan of each student referred by NMLOKS via fax or mail within 48 hours of the completion of services and when the product becomes available for pick up.

Note: The parents of the referred student have signed a waiver for you to release the above information to NMLOKS.

_____ _____ _____

Signature Printed Name Date

Please return this form to:

Brenda Dunn, Program Manager
New Mexico Lions Operation KidSight
www.NMLionsKidSight.com
Email: nmlionskidsight@gmail.com

1501 North Solano Drive
Las Cruces, New Mexico 88001
Phone: 575-525-5631 / Fax: 575-524-1699