



# STANTON LIONS CLUB SIGHT AND HEARING COMMITTEE

Date \_\_\_\_\_

APPLICANT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_

APPLICANT'S SCHOOL \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

PARENT'S ADDRESS \_\_\_\_\_

STREET

CITY

STATE

ZIP

PARENT'S OCCUPATION \_\_\_\_\_

TOTAL FAMILY INCOME \$ \_\_\_\_\_ NUMBER OF DEPENDENTS \_\_\_\_\_

VALUE OF FAMILY PROPERTY \_\_\_\_\_

IS APPLICANT COVERED FOR VISION CARE BY MEDI-CAL? \_\_\_\_ A UNION PLAN? \_\_\_\_  
MEDICAL INSURANCE? \_\_\_\_ CARRIER \_\_\_\_\_ POLICY # \_\_\_\_\_

REASON(S) FOR REQUESTING MEDICAL INSURANCE: \_\_\_\_\_

**I HEREBY CERTIFY THAT THE FOREGOING INFORMATION IS A CORRECT STATEMENT OF FACT.**

\_\_\_\_\_  
SIGNATURE OF PARENT (OR APPLICANT IF OF AGE)

REFERRED BY:

NAME \_\_\_\_\_ TITLE \_\_\_\_\_

ADDRESS \_\_\_\_\_

BASIS OF REFERRAL \_\_\_\_\_

HAS THERE BEEN A PREVIOUS EYE EXAMINATION? \_\_\_\_ WHEN \_\_\_\_\_

PAID FOR BY LIONS CLUB? \_\_\_\_ CONTACT NUMBER (\_\_\_\_) \_\_\_\_\_

MAIL TO:  
STANTON LIONS CLUB  
SIGHT AND HEARING COMMITTEE  
10581 CHESTNUT ST.  
STANTON, CA 90680