



## *Sight for Students* Benefit Form

TO: Wyoming Optometric Association  
P.O. Box 1967  
Cheyenne, WY 82003  
**FAX: 307.634.0939**

From: \_\_\_\_\_  
School Nurse School District

\_\_\_\_\_  
School Address / City / ZIP

\_\_\_\_\_  
School Nurse Signature

I wish to recommend the following child for the VSP/WOA *Sight for Students* Program and have verified that they have met the following criteria for eligibility:

- Family income is 200% or less than poverty level
- Child is not enrolled in Medicaid, Kid Care or other vision insurance
- Child is 18 years of age or younger or has not graduated from high school
- Child or parent is US citizen or resident alien with a social security number
- Child has not used the program during the last 12 months

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Student's Address / City / ZIP

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Today's Date