Newfoundland & Labrador Association of Optometrists

Newfoundland Labrador

NL Eye See Eye Learn Program Application

Is My Child Eligible?

- ☐ **Starting Kindergarten in 2025**
- ☐ Lives in Newfoundland and Labrador, and
- ☐ Has a valid MCP Card

If yes to all, and your child does not have private insurance which fully covers the cost of an eye exam (up to $90.00 max is covered under the program for an eye exam, including any insurance payments) your child is eligible for a free eye examination and one pair of prescription eyeglasses (if required) from the Essilor Foundation Eye See Eye Learn Glass Kit.

How Can My Child Participate?

a. Book an appointment with an Optometrist to arrange an eye examination for your child. Find an Optometrist at http://nlao.org/public/find-optometrist/

b. Complete the application form and give it to the Optometrist at your child's eye examination.

c. If your child is covered by insurance, please bring a copy of your insurance documents to your appointment.

Name of Child:	
Date of Birth: DD / MM / YYYY	MCP Number: _ _ _ / _ _ _ /_ _ _ / _ _ _
Name of School:	
City or Town:	Child's Postal Code: _ _ _ _ _ _

_____ DD / MM / YYYY

Signature of Parent / Guardian **Date**

Privacy Statement

The personal information collected in this form will be used for the purpose of assessing eligibility for and evaluation of the Eye see Eye Learn Program. The information is collected under the authority of section 61 (a) (c) of the **Access to Information and Protection of Privacy Act, 2015**. If you have any questions about the collection, use or disclosure of the personal information, please contact healthinfo@gov.nl.ca.

Part B – For Optometrist Use Only

Name of Optometrist: _____
License Number: _____

Date of Vision Examination: DD / MM / YYYY
Location of Examination (if not office): _____
Glasses Prescribed: Yes ☐ No ☐
Glasses Provided by Program: Yes ☐ No ☐
Referral to Ophthalmologist: Yes ☐ No ☐

Total Invoice Amount (maximum $90 per eye exam)	$
Amount Covered by Insurance or Other Agency	$
Amount Requested for Reimbursement	$
Was the patient charged directly for this service: Yes ☐ No ☐	
*If the patient was charged for this service, indicate the amount paid by the patient	$

_____ _____
Signature of Optometrist Date

Part C – Declaration of No Insurance

This section is to be completed only if your child is not eligible for reimbursement of the cost of an eye examination from private health insurance or any other agency.

I certify that _____ _ _ _ / _ _ _ / _ _ _ / _ _ _
(Child's full name) (Child's MCP number)
is not eligible for reimbursement of the costs listed above* by private health insurance or from any other agency.

_____ DD / MM / YYYY
Signature of Parent/Guardian **Date**