

**Child/Student's Eye Doctor Information  
KanLovKids Program**

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please ask the parents to provide complete information on their child's eye doctor(s).**

Ophthalmologist's Name: \_\_\_\_\_

Clinic's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) Zip

Telephone Number: \_\_\_\_\_

Optometrist's Name: \_\_\_\_\_

Optometrist's Office Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) Zip

Telephone Number: \_\_\_\_\_