**Preschool Vision Screening Ambassador Application**

Thank you for applying for the Prevent Blindness Wisconsin Preschool Ambassador Program. Each year, Prevent Blindness Wisconsin chooses one Preschooler who did not pass their vision screening to represent and support our mission to prevent blindness and preserve sight. If chosen, your child will represent Prevent Blindness Wisconsin at several events throughout the year including but not limited to:

* Prevent Blindness Wisconsin's Annual Meeting- Tuesday, May 21, 2019
* Swing for Sight Golf Outing- Monday, June 3, 2019
* Lizzy’s Walk Fundraiser- Wednesday, July 31, 2019
* Celebrity Waiters Dinner- Date TBD (Fall 2019)
* Photo sessions, interviews, and other public appearances

*Note: to be considered as a potential candidate for the Preschool Ambassador Program, you must include a photo of your child and return this application by April 8, 2019. Please return form by mail (731 N. Jackson Street, Suite 405, Milwaukee, WI 53202) or email to April@pbwi.org.*

**Child's Name:**   **Birthdate: \_\_\_\_\_\_\_\_\_\_**

**Parent(s)/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:**   **Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Day Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Evening Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vision Screening Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision Screening Date: \_\_\_\_\_\_\_\_\_\_**

**Your Child’s Eye Doctor:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Child’s Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Does your family have a history of vision problems?:** **[ ]** YES [ ]  NO

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**My child currently wears glasses:**  [ ]  YES [ ]  NO

**My child is undergoing treatment for a vision or eye health problem:** [ ]  YES [ ]  NO

 If yes, what does treatment involve? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**To help us choose a Preschool Ambassador, please answer the following questions:**

Did you think your child had a vision problem? Why or why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How does your child’s diagnosis make you feel? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How has your child changed since they started treatment/ wearing glasses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What is the hardest part of treatment/ wearing glasses for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How does your child feel about treatment/ wearing glasses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Would you recommend a Children’s Vision Screening to friends or family with children? Why or why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***By submitting this application, I give Prevent Blindness Wisconsin permission to use my child’s story and photo in any promotions, advertisements, publications, and more, as seen fit by Prevent Blindness Wisconsin.***

SIGNED:  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please contact April Thaney, Children’s Vision Screening Coordinator, at (414) 765-0505 with any questions. Please return form by April 6, 2019 by mail (731 N. Jackson Street, Suite 405, Milwaukee, WI 53202) or email to* *April@pbwi.org**.*