



Vision Travel Permission

Dear Parent/Guardian:

Your child _____ is scheduled for a medical appointment
on _____, at _____ a.m. /p.m., with Dr. _____,
in _____ for _____.

Please check yes or no and sign your name and date below.

_____ Yes, He/ She may go.

_____ No, He/ She may not go.

Parent Signature

Date

* Each medical trip will need new permission form signed and dated.

