



**Vision Service Plan- *Sight for Students* Program Response Form**

Agency/School Contact \_\_\_\_\_

Agency/School Name \_\_\_\_\_

Agency/School Address \_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

E-Mail Address \_\_\_\_\_

What eye care services are you currently using? \_\_\_\_\_

\_\_\_\_\_

**Please circle all that you are interested in:**

I would like additional information about the VSP *Sight for Students* program.

I would like to learn more about FREE Preschool Vision Screening Training and equipment.

I would like to know how I can volunteer with Prevent Blindness Ohio.

**Please mail or fax the completed response form to:**

Prevent Blindness Ohio  
1500 W. Third Ave., Suite 200  
Columbus, OH 43212  
Attn: Lauren Mackowiak  
Fax: 614-481-9670

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

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