



HEALTH SERVICES & PROGRAMS

POMONA UNIFIED SCHOOL DISTRICT

800 S Garey Avenue, P.O. Box 2900, Pomona, California 91766 Phone: (909) 397-4648, ext. 28352

Cover letter For Vision Application

To the Parents/Guardians of: _____.

Thank you for requesting assistance for vision care for your child. Vision care is available through Health Services in cooperation with volunteer optometrists and the Pomona Host and Breakfast Lions Clubs. Enclosed is the application that must be completed.

Attach all requested documentation relating to income. Return the application with the requested documents to your child's school nurse; the paperwork will be submitted to Health Services for approval.

If you are approved, you will be notified by staff and scheduled for an appointment.

Sincerely,

School Nurse/ Health Assistant

When you return the application for vision care, please return the following:

_____ Proof of income

_____ Proof of Medi-Cal coverage, if applicable

If you have any questions, please call me at 397-_____

Thank you.

SECTION 7