See to Learn Foundation | Children's Vision Initiative

VISION GRANT APPLICATION

Contact Name: _____ Title: _____

School District: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Student Name: _____ Student ID#: _____

Parent/Guardian Name: _____ Phone: _____

Reason for applying for grant: ☐ Failed vision screening ☐ Reported trouble in classroom

_____

_____

Other funding/resources which have been utilized: _____

_____

Please note this grant should be applied for after seeking assistance from other existing resources.

Authorized School Representative: _____ Title: _____
(If applicable)

Signature: _____ Date: _____

Please complete and return this application to See to Learn Foundation.

785.232.0225 | visiongrant@seetolearnfoundation.org | 632 SW Van Buren St., Ste. 100, Topeka, KS 66603