

School Information

School Name: School Address:
City / Province / Postal Code: School Phone Number:

Student Leader Information

Student Name: Grade/Year:
Email Address:
Phone Number:

Program Details

How Would You Like Your School to Participate? (Check all that apply) Collect Glasses Fundraising Event Both

Number of Donation Boxes Requested:

Proposed Start Date:

Proposed End Date (if applicable):

Additional Information

Where will the donation box(es) be placed in your school?

School Staff Contact Person (if applicable):

Name:

Role:

Year:

Acknowledgement

By signing below, you confirm your school's interest in joining the Specs4Sight program and agree to maintain the donation boxes in a visible, secure location

Student Signature: _____ Date: _____

School Staff Sponsor Signature (if required): _____ Date: _____

Specs4Sight Program Manager: _____ Date: _____

Once this form is processed by the Program Manager, you will receive a confirmation email, and your Specs4Sight kit will be delivered to the school address you provide within 10–15 business days.