FREE VISION SCREENING
District 14-U Lions KidSight Program

PARENT/GUARDIAN CONSENT FORM

Dear Parent/Guardian,

The _____ Lions Club will be offering free eye screening to your child at _____. The screening uses state-of-the-art technology and is highly effective in detecting the vision problems including far- and nearsightedness, astigmatism, strabismus (commonly called "crossed eyes"), anisometropia (unequal prescriptions) and media opacities (i.e. cataracts). Many of these issues can lead to amblyopia (commonly called "lazy eye"). No physical contact is made with your child and no eye drops or medications are used.

I, the undersigned, hereby give permission for my child to participate in the eye screening event. I understand the following regarding this program:

1. The information obtained from this vision screening is preliminary only, and does not constitute a formal eye exam. Not all vision problems will be detected by the vision screening process.
2. There is no charge to participate in the vision screening process.
3. I will not hold the Lions Club organization(s) or their sponsors accountable for any errors of commission, omission or other inaccuracies of the reported screening results.
4. If my child fails the eye screening, I will receive a referral to an eye care specialist with the results of the screening. I understand that I am responsible for arranging a full eye exam if my child has been referred as a result of the vision screening.
5. If my child's reading is unreadable, the Lion volunteers who conducted the original screening may schedule re-takes at another time.
6. You are giving consent for the volunteers of District 14-U Lions KidSight Program to: (1) Record and store the results of your child's eye screening; (2) Contact you with the results of the eye screening; (3) Contact your eye care doctor with the results of the eye screening; and (4) If your child is being screened as part of a school program, to release the results to the school contact of the participating school to assist in follow-up. (5) If your child is referred to an eye doctor you are also giving consent for your eye care doctor to share the results of your follow-up examination with District 14-U Lions KidSight Program who will enter that information into their database. All information you or your eye care doctor give to us will be kept confidential. Any information that could identify your child or family will not be used without your permission.

PLEASE PRINT and ANSWER ALL QUESTIONS

Child's Full Name _____ Male__ Female__

Child's Date of Birth _____ Child's Age _____ School Name _____

Parent or Guardian _____ E-mail _____

Address _____ City _____ Zip Code _____

Phone INCLUDING area code _____

Is your child under the care of an eye doctor? Yes___ No___

If so, name of eye doctor/date of last exam: _____

All information is kept confidential and is not sold to third parties.

☒ Parent/Guardian Signature: _____ Date: _____

For Official Use Only

The result of your child's vision screening is as follows:

_____Pass We did not detect a vision problem at this time. REMEMBER, screening is not a substitute for a complete eye exam. Consult your eye care professional if you suspect a vision problem.

_____Refer Your child should be examined by an ophthalmologist or optometrist in your area because he/she may have the following condition that has the potential to cause poor vision in one or both eyes.

____ High Farsightedness
____ High Nearsightedness
____ Astigmatism
____ Other - _____
____ Crossed or misaligned eyes
____ Difference in prescription between eyes
____ Media opacity

Attach results