Kentucky KidSight

Consent Form

Free vision screening will be offered to your child by the local Lions Clubs in your community in conjunction with the Kentucky Lions Eye Foundation. The screening provides instant photographs of your child's eyes to determine the presence of eye disorders including far and nearsightedness, astigmatism, strabismus (misaligned eyes), anisometropia (unequal refractive power), and media opacities (i.e. cataracts). No physical contact is made with your child and eye drops are not necessary. This screening is approximately 85-90% effective in detecting problems that can cause decreases in vision.

I, the undersigned, hereby give permission for my child, _____, to participate in the 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 diagnosis of vision problems.
2. There is no charge to participate in the vision screening process.
3. **If my child is referred** I will receive a sealed Parent To Do Packet with the results of the screening through the Kentucky KidSight Program.
4. **If my child's photo is unreadable** the Lions Volunteer who conducted the original screening will schedule re-takes at the screening site.
5. 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. I give permission for my doctor to share the evaluation results with the Kentucky Lions Eye Foundation.
6. I will not hold either the Lions Club organizations or the Kentucky Lions Eye Foundation accountable for any errors of commission, omission or other misdiagnosis.

_____ _____

Signature of Parent or Guardian Date

DO NOT COMPLETE FORM IF
Your child was screened last year or
If your child is currently under treatment for his/her vision

Child's Name: _____ **Male** ☐ **Female** ☐

First **Middle** **Last**

Please write child and parent's name on back side of this form.

Child's Date of Birth: _____ **Child's Age (1-5 years):** _____

Parents or Guardian: _____ **County:** _____

Address: _____ **City and ZIP:** _____

Family Physician: _____

Vision Screening every two years is sufficient

Is your child currently under the care of an **Eye Doctor**? Yes ☐ No ☐

Name of Eye Doctor: _____ Phone:( ) _____

Have we previously screened your child's vision? Yes ☐ No ☐ Not sure ☐