



Kentucky KidSight Pre-Screening Sheet

Club: _____ District: _____

Club contact: _____ Phone Number: _____

Address _____ (city) _____ (zip) _____

Photographer: _____ Escort: _____

Recorder: _____

Name of site: _____ Date of screening: _____

Expected number of children _____

Approximate number of Polaroid™ Pictures needed _____

Surrounding cities _____

County _____

Names of cooperative eye professionals (Ophthalmologists or
Optometrists) who currently work closely with your
club _____

(Only necessary if you have not previously provided this information.)

FAX to: KidSight 502-852-6596