



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 results 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 used. This screening is approximately 85-90% effective in detecting problems that can cause decrease 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 complete diagnosis of vision problems.
2. If my child is referred, I will receive a sealed Parent Packet with the results of the screening through the Kentucky KidSight Program.
3. I understand that it is my responsibility to arrange for a full eye exam if my child is referred because of the vision screening. I give permission for my doctor to share the evaluation results with the Kentucky Lions Eye Foundation.
4. All information is kept confidential with the Kentucky Lions Eye Foundation.
5. 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

(PLEASE PRINT BELOW)

Child's Name: _____ Male Female
 First **Middle** **Last**

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

Parents or Guardian: _____ Phone Number: _____

E-mail Address (optional): _____

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

RESULTS: ___ REFER	___ PASS
___ UNREADABLE	___ Currently Under Treatment