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 95% 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. This screening does not take the place of a complete eye exam.
2. <u>If my child is referred</u>**,** I will receive a Parent Packet with the results of the screening through the Kentucky KidSight Program.
3. All information is kept confidential with the Kentucky Lions Eye Foundation.
4. 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 (6 months to 6-years): _____

Parents or Guardian: _____ Phone Number: _____

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

**** * please check result below * ****

RESULTS: **___ PASS** **___ REFER** **___ CUT** (currently under treatment)