CONSENT FORM

Please Print All Information

**** Do not complete form if child is currently under care of an eye doctor****

Child's Name:_____
First **Middle Initial** **Last**

Child's Date of Birth:_____**Age**_____

Address:_____

City and Zip:_____

Phone (____) _____

E-mail:_____

PASS ____

REFER ____

If it is a referral, attach label here if refraction is obtained.

Dear Parent/Guardian:

The local Indiana Lions Clubs in your community will offer free eye screening to your child. The screening may pick up the presence of eye disorders including farsightedness and nearsightedness, astigmatism, strabismus (misaligned eyes), anisometropia (unequal prescriptions) and media opacities (i.e. cataracts). 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 Indiana Lions Eye Bank, Inc., the Lions Club organizations, their sponsors or Operation KidSight accountable for any errors of commission, omission or other inaccuracies of the reported screening results.
4. This form and your child's screening results will be forward to Operation KidSight for review.
5. If my child fails the eye screening, he/she will be referred to an eye care specialist and I will receive a "Parent-To-Do Packet" along 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.
6. You are giving consent for the employees and volunteers of Operation KidSight to: (1) Record and store the results of your child's eye screening in a computer database; (2) Contact you with the results of the eye screening; (3) Contact your eye care doctor with the results of the eye screening; (4) If your child is a participant in a county Head Start or Community Action Program, to release the results of the screening to the manager of the Head Start/Community Action Program to assist in follow-up; and (5) If your child fails the eye screening, you are also giving consent for your eye care doctor to share the results off your follow-up comprehensive eye examination with Dr. Daniel Neely, Operation KidSight Medical Director, and the staff of Operation KidSight who will enter that information into the computer database. All information you or your eye care doctor give to Operation KidSight will be kept confidential. Any information that could identify your child or family will not be used without your permission.

X Parent/Guardian Signature:_____ **Date:**_____

_____Parent or guardian will be notified in the event the results of this screening indicate the child is at risk for an ocular problem. Initial here to OPT OUT OF FOLLOW UP CALL OR E-MAIL. *If your child participates in a <u>Head Start/Community Action Program,</u> we are required to follow up and this option is not available to you.*

OFFICE USE ONLY

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

_____Pass We are unable to detect a vision problem at this time. The 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 because he or she may have the following condition that has the potential to cause poor vision in one or both eyes. Please take your child to see an ophthalmologist or optometrist in your area**. If you have any questions about your results please call Operation KidSight at (317) 220-8486**

_____Strabismus (Crossed or misaligned eyes)
_____Anisometropia (Difference in need for glasses between eyes; can cause poor vision in one eye)
_____Astigmatism (Results from unequal focusing of light rays as they enter the eye, causing a blurring of objects)
_____High Farsightedness (Can contribute to eye crossing)
_____High Myopia (Severe near vision)
_____Anisocoria (Inequality in size of pupils)
_____Automatic referral when child is cooperative and no refraction obtained