Lions SEE, Inc.

A partner with KidSight USA

STUDENT NUMBER

CONSENT FORM

PLEASE PRINT

Child's Name: _____ **DOB:** _____
FIRST LAST MONTH/DAY/YEAR

Parent/Guardian: _____
FIRST LAST

Address: _____
STREET CITY STATE ZIP

Phone: **H:**_____ **C:**_____ **W:**_____

Has parent/guardian noticed any vision problems in child?_____

_____

IMPORTANT: The _____ *Lions Club* provides free vision screening as a community service. While the ***Vision Screener*** is a very sophisticated scientific, clinical instrument, it may produce either false positive or false negative results. It is intended to assist in identifying significant ocular conditions, which may lead to amblyopia (Lazy Eye). If the child is not referred as a result of this screening but the parent/guardian has concerns, the child should receive a comprehensive eye examination by an eye doctor. This screening is not intended to be a substitute for a comprehensive eye examination.

I have read the above disclaimer and give permission for the Lions Club to perform this vision screening.

_____
Parent/Guardian Signature **Date**

The parent/guardian will be notified if the results of this vision screening indicate the child is at risk for an ocular problem. You will not be notified if the results do not indicate a problem.
OPT OUT OF FOLLOW-UP CALL [ ]

PASS [ ]

REFER [ ]

8/2015