FREE Vision Screening
Colorado Lions KidSight Program

Office Use Only:

SN#_____

The local Lions Club in your community, in conjunction with the Rocky Mountain Lions Eye Bank, will offer free vision screening to your child at his/her preschool or kindergarten. The screening uses state-of-the-art technology and is 85-90% effective in detecting the vision problems that could lead to lazy eye. No physical contact is made with your child and no eye drops or medications are used.

WHY VISION SCREENING? *1 in 20 children has an undetected vision problem that could turn into lazy eye if left untreated. Early detection and treatment is essential to prevent lazy eye.*

Parent/Guardian: Please fill out the following. All information is kept confidential and is not sold to third parties.
PLEASE PRINT and ANSWER ALL QUESTIONS

Child's Full Name _____ [_____] Male___ Female___
First Middle Last 3 Initials

Child's Date of Birth _____ Child's Age _____ _____
Month Day Year School Name

Parent or Guardian _____ Email _____

Address _____City _____ Zip Code _____

Phone INCLUDING area code _____ 2nd Phone _____

Is your child currently under the care of an eye doctor? Yes ☐ No☐ If yes, name of eye doctor: _____

CONSENT:

I hereby give permission for my child to participate in the screening event. I have read and understand the following information regarding this program:

- The information obtained from this vision screening is preliminary only and does not constitute a diagnosis of vision problems. Not all vision problems are detected by the vision screening process.
- I may be communicated by telephone if my child does not pass the vision screening.
- I understand that if my child does not pass the eye screening, I am responsible for arranging for an eye exam with an eye doctor of my choice. I understand that I am responsible for all costs of any eye exams.
- I will not hold the Lions organization, the Rocky Mountain Lions Eye Bank, their employees, agents, officers, and representatives liable for any injury which may accrue as a result of the vision screening, including but not limited to errors of commission, errors of omission or other misdiagnosis.

_____ _____
Signature of Parent or Guardian Date

VOLUNTEER:

Please ***TAPE*** *Child's Vision Screening Readout at* ***top of edge*** *and label with* ***child's initials*** *and* ***date of birth***

RESULTS: For Office Use Only

____Pass We are unable to detect a vision problem at this time. This screening is not a substitute for a complete pediatric eye exam. Consult an eye care professional if a vision problem is suspected.

____Borderline Your child *may be developing* a mild refractive error that does not need to be formally evaluated at this time. We recommend the child be re-screened by an eye care professional in one year or sooner, if a vision problem is suspected.

___Unreadable We were unable to get reliable vision screening results for this child. This can happen occasionally if the child looks away from the blinking light during the screening. Consult an eye care professional if a vision problem is suspected.

____Refer Child should be examined by an eye care professional because he/she ***may*** have the following condition:

_____ Strabismus _____ Anisometropia
_____ Astigmatism _____ High Farsightedness
_____ High Myopia _____ Other: _____

General Use *Revised 3-15-10*