Louisiana Lions Eye Foundation

CUBSIGHT VISION SCREENING

CONSENT & REFERRAL FORM

For more information call (504) 525-7235

PLEASE PRINT CHILD'S INFORMATION:

Child's Name: ______________________________ ____ ______________________________
First M/I Last

Child's Date of Birth:______/______/______ Child's Age: _________ Male:_______ Female:_______

Address:____ Apt. ___________

City: ____ZIP___________________ Parish:________________________

Is your child currently under the care of an Eye Doctor? _____YES _____NO Does your child wear glasses? _____YES _____NO

School Name: ____________________________________ **Teacher's Name**: _______________________________________

PLEASE PRINT PARENT CONTACT INFORMATION:

Parent's Name: ____

Email: ____

Phone: ( ) ____________---______________ Work/other ( ) ______________---_________________

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 vision exam. It is designed to potentially detect eye problems such as myopia (near-sightedness), hyperopia (far-sightedness), astigmatism (not seeing things in focus), strabismus (eyes point in different directions), amblyopia (lazy eye), or anisocoria (different size pupils).**
2. **The eye screening is done using a camera that takes a picture/reading of your child's eyes. No medication is needed to complete the screening. The screener stands approximately 3-4 feet away from your child. There is no charge to participate in the vision screening process.**
3. **I give permission for the Louisiana Lions Cubsight Program to take a picture of my child.**
4. **If referred, I authorize the examiner to release the results of my child's exam to the Cubsight Program and/or my child's school/day care.**
5. **I understand that I am responsible for arranging a complete eye exam by a vision professional if my child has been referred.**
6. **I will not hold the Lions Club organizations, the Louisiana Cubsight Program, or the Louisiana Lions Eye Foundation accountable for any errors or omissions obtained by this screening.**
7. **If my child receives a refer outcome, I will be contacted by a school employee or a member of the Cubsight staff in reference to my child's results from this screening.**

X_______________________________________ _______________
Signature of Parent/Guardian *Date*

If the child wears glasses, did the child have their glasses on? ***Yes***______ ***No*** _______

PASS

PASS The screening was unable to detect a problem at this time. Please realize this screening is not a substitute for a comprehensive pediatric eye exam.

If you suspect a vision problem, please consult a vision professional.

CAMERA

RESULTS

GO

HERE

REFER

REFER Your child did not meet the criteria to pass our vision screening. We recommend that your child see an Eye Doctor for a complete Vision Exam.

Someone from our Cubsight program will contact you soon with additional information. Meanwhile, please feel free to contact us with any questions at (504) 525-7235.