



Louisiana Lions Eye Foundation Cubsight Program Vision Screening Consent and 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'S INFORMATION:

Parent's Name: _____

Phone: () _____ --- _____ () _____ --- _____
Primary Secondary

E-mail: _____

I, the undersigned, hereby give permission for my child, _____, to participate in the screening event. I understand the following regarding this program:

- 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).
- 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.
- I give permission for the Louisiana Lions Cubsight Program to take a picture of my child.
- 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 facility.
- I understand that I am responsible for arranging a complete eye exam by a vision professional if my child has been referred.
- 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.
- 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.

Place results sticker here

REFER

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

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

If you are interested in learning more about Lions Clubs or interested in joining, contact: _____