Louisiana Lions Eye Foundation

FREE Vision Screening

CONSENT & REFERRAL FORM

For more information call (504) 525-7235

PLEASE PRINT CHILD'S INFORMATION

Child's Name: _____ _____ _____
First mid initial Last

Date of Birth: _____/_____/_____ Age: _____ Male:_____ Female:_____

Is your child 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: (_____) _____-_____ Secondary ph (_____) _____-_____

Address:_____ Apt. _____

I, the undersigned, hereby give permission for my child, _____ , to participate in the LLEF CubSight Vision Screening. I understand the following regarding this program:

1. The information obtained from this vision screening is preliminary 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. There is **no charge** to participate in the vision screening. The 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.
3. The LLEF CubSight screener or volunteer may take a picture of my child which could possibly be used in future CubSight promotions.
4. If my child is referred, I am responsible for arranging a complete eye exam by a vision professional.
5. If my child is referred and examined by a vision care professional, the examiner should release the results of my child's exam to the CubSight Program and to my child's school/day-care. These results may not remain confidential as they will be shared with my child's school/day-care administration.
6. I will not hold the Lions Club organizations, the LLEF 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 should be notified by the school and may be contacted by the LLEF CubSight staff to follow up on my child's vision screening. I may contact the LLEF CubSight staff at any time with questions or concerns regarding my child's vision screening.

X_____ _____
Signature of Parent/Guardian *Date*

Was the child wearing glasses when screened? _____ *Yes* _____ *No*

PASS

PASS The screening did not detect a vision problem.

UNABLE to SCREEN

We were unable to obtain a clear result on your child.

We recommend that your child receive a complete vision exam by an eye doctor.

REFER

REFER Your child did not pass our vision screening.

We recommend that your child receive a complete vision exam by an eye doctor.

If you would like more information about the Lions Clubs, please contact: _____