Sight for Kids

CONSENT FORM

For more information call (504) 525-7235

"SPONSORED BY"

PLEASE PRINT PARENT CONTACT INFORMATION

Parent's Name:____

Email: ______________________________ Phone: (_______) _____________-_____________

PLEASE PRINT CHILD'S INFORMATION

Child's Name: ______________________ ________ ______________________
First mid initial Last

Date of Birth: _______ /______ /________ Age: _________ Male:_______ Female:_______

I, the undersigned, hereby give permission for my child, to receive a FREE comprehensive dilated eye exam, and a FREE pair of glasses , knowing this exam requires medicine to dilate my child's eyes.

1. I understand there is **no charge** to participate in this free vision program, nor will there be any cost for glasses.
2. I will not hold the Lion Club organization, the LLEF Sight for Kids Program, the attending physicians, or the Louisiana Lions Eye Foundation accountable for any errors or omissions caused during this program.

Signature of Parent/Guardian: ________________________________Date__________

CLINIC RESULTS BELOW ONLY

RX:	SPHERE	CYLINDER	AXIS	PRISM	BASE	ADD
RIGHT						
LEFT						

	P.D.
FAR	
NEAR	
TOTAL	

FRAME NAME/NUMBER	COLOR	A	B	ED	TEMPLE LENGTH

FRAME NAME/NUMBER	COLOR	A	B	ED	TEMPLE LENGTH

Doctor's Comments:

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