Session #________
for office use only

Lions SEE, Inc.
At the Ira G. Ross Eye Institute
1176 Main St., Buffalo, New York 14209
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Preschool Vision Screening
♥Consent Form♥

Consent of Parent/Guardian

Free vision screening will be offered to your child by the Lions Club Organization in conjunction with the Lions SEE Program at the Ira G. Ross Eye Institute. The screening provides instant photographs or a digital reading of your child's eyes to determine the presence of eye disorders including far and nearsightedness, astigmatism, and anisometropia (unequal refractive power), and media opacities (i.e. cataracts). No physical contact is made with your child and eye drops are not necessary. The screening is approximately 85-90% effective in detecting problems that can cause decreases in vision.

I, the undersigned, hereby give permission for my child, named below, 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 diagnosis of vision problems.
2. There is no charge to participate in the vision screening process.
3. I understand that I am responsible for arranging a full eye exam if my child has been referred as a result of the vision screening. I give permission for my doctor to share the evaluation results with Lions SEE Program at the Ira G. Ross Eye Institute.
4. I will not hold either the Lions Clubs Organization or Lions SEE Program at the Ira G. Ross Eye Institute or the school or facility where the screening is held accountable for any errors of commission, omission or other misdiagnosis.

PLEASE PRINT

____________________ ________________ ________ __________________________________

Name of Parent or Guardian *Signature* *Date* *Child's First, Middle Initial and Last Name*

______________ _____ __________________________________ _______ __________

Child's date of Birth *Age* *Address* *City* *Zip Code*

Home Phone (_____)______________________ *2nd Phone* (_____)____________________________

Do Not Complete Form *if your child is currently under Vision treatment- Screening every 2 years is sufficient-*

Results If you have any questions about your results contact (716) 881-7915.

____ **PASS** (We are unable to detect a vision problem at this time. The screening is not a substitute for a complete exam. Consult your eye care professional if you suspect a vision problem.)

____ **REFER** Your child should be examined by an eye care Professional because he/she may have the following condition that has the potential to cause poor vision in one or both eyes:

__**Anisometropia** *(Difference between eyes; can cause poor vision in one eye)*
__**Astigmatism** *(Possible need for glasses)*
__**Hyperopia** *(High Farsightedness (Can contribute to eye crossing)*
__**Myopia** *(near Sightedness)*
__**Other** ____
__**Unreadable**, *Refer (we were unable to obtain acceptable reading)*

☐Focus *(top/bottom)* ☐ 4-8 mm pupils *(top/bottom)* ☐ fixation *(top/bottom)* ☐ 4 pupils *(top/ bottom)*

If your child is referred from this screening, **please take them to see an ophthalmologist or optometrist** in your area.
Bring with you this form along with the Evaluation Sheet (Included in this packet) to your appointment for the eye doctor to complete.

The Volunteer Will Staple Your Child's Vision Screening Photo Or Welch Allyn SureSight Digital Printout Here

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