Operation Kid Sight Screening
Spring Branch Bulverde Family Lions Club

CONSENT FORM

Please Print All Information

**Do not complete this form if child is currently under care of an eye doctor*

*Child's Name: _____
First Middle Initial Last

Child's Date of Birth: _____

Address: _____

City and Zip: _____

Phone: _____

E-mail: _____

Dear Parent/Guardian:

The SBB Lions Club in your community offers free eye screening to your child. The screening may pick up the presence of eye disorders including farsightedness and nearsightedness, astigmatism, strabismus (misaligned eyes), anisometropia (unequal prescriptions) and media opacities (e.g., cataracts). No physical contact is made with your child and no eye drops or medications are used. I, the undersigned, hereby give permission for my child to participate in the eye 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 formal eye exam. Not all vision problems will be detected by the vision screening process.
2. There is no charge to participate in the vision screening process.
3. I will not hold the Lions Club organizations, their sponsors, or Operation Kid Sight Screening accountable for any errors of commission, omission, or other inaccuracies of the reported screening results.
4. This form and your child's screening results will be forward to the organization facilitating the screening for review.
5. If my child fails the eye screening, he/she will be referred to an eye care specialist and I will receive a printed results sheet depicting the results of the screening. I understand that I am responsible for arranging a full eye exam if my child is referred because of the vision screening.
6. You are giving consent for the Lions volunteers of Operation Kid Sight Screening to:
    a. Record and store the results of your child's eye screening in a computer database
    b. Contact you with the results of the eye screening
    c. Provide your eye care doctor with the results of the eye screening
    d. Parents will be notified in the event the results of this screening indicate the child is at risk for an ocular problem

Parent/Guardian's Signature: _____ **Date:** _____

All information you or your eye care doctor give to Lions of Operation Kid Sight Screening will be kept confidential. Any information that could identify your child or family will not be used without your permission. The screening is not a substitute for a complete eye exam. Consult your eye care professional if you suspect a vision problem.