

# MD5M Lions KidSight

## Consent Form

Date of Screening: May 4, 2019.

Is this child currently under the care and treatment of an eye doctor?  No  Yes

Free vision screening will be offered to children by the Clear Lake Lions Club. Screening events are sponsored by the MD5M Lions KidSight Foundation, Inc. Vision screening produces images of a child's eyes to determine the presence of eye disorders including far- and near-sightedness, in addition, astigmatism, anisometropia (unequal refractive power), strabismus, (misaligned eyes), and media opacities (e.g., cataracts) which may result in amblyopia (lazy eye). No physical contact is made with a child and no eye drops are used during the vision screening. This screening is approximately 85-90% effective in detecting problems that can cause reduced vision.

Participation is voluntary. This screening is designed for pre-school-aged children. Children who are younger than 6-months old will not be screened. **No child will be screened without a signed and completed consent form. If more than one child from the same family is being screened list their name(s) on the reverse side of this form.** There are no foreseeable risks to participating in the MD5M Lions KidSight vision screening.

Please print or type the information below:

Child's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY) Child's Age \_\_\_

Parent's Name: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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

1. The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision problems.
2. There is no charge to participate in the screening event.
3. I will be contacted with the results of the screening through Lions KidSight.
4. I am responsible for arranging a full eye examination with a doctor of my choosing if my child has been referred as a result of the vision screening. Lions KidSight recommends a dilated eye examination.
5. The results of your child's eye examination will be anonymously compiled with other children's exams to monitor the effectiveness of the screening process.
6. MD5M Lions KidSight will maintain the confidentiality of all records and results.
7. I will not hold the Lions Club and its volunteers or Lions Clubs organizations, accountable for any errors of commission, omission or other misdiagnosis.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Child's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male \_\_\_\_ Female \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY) Child's Age \_\_\_\_

Is this child currently under the care and treatment of an eye doctor?  No  Yes

Child's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male \_\_\_\_ Female \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY) Child's Age \_\_\_\_

Is this child currently under the care and treatment of an eye doctor?  No  Yes

Child's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male \_\_\_\_ Female \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY) Child's Age \_\_\_\_

Is this child currently under the care and treatment of an eye doctor?  No  Yes

Child's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male \_\_\_\_ Female \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY) Child's Age \_\_\_\_

Is this child currently under the care and treatment of an eye doctor?  No  Yes