VISION SCREENING CONSENT FORM

The Newtown Visiting Nurse Association (NVNA) and the Newtown Lions Club (operating under the Connecticut Lions Eye Research Foundation (CLERF) and the Lions Eye Health Program) are conducting a free vision screening for children at designated schools and facilities in the town of Newtown. The screening equipment (Welch Allyn Vision Screener – Model VS100) used in the screening may determine the presence of eye disorders including far and near sightedness, astigmatism, anisometropia (difference in prescription between eyes), strabismus (eye turn), and anisocoria (unequal pupil size). The screening process is conducted at a distance of approximately three feet from the subject. There is no physical contact with your child and no eye drops will be administered.

I, the undersigned, give permission for my child, _____
to participate in the eye screening program. (Print child's name here)

Child's Age _____ Male ____ Female _____ Child's Date of Birth _____

I have read and understand the following information about this eye screening program:

1. The information and results obtained from this eye screening program are preliminary only and does not constitute a complete eye exam or diagnosis of vision problems.
2. There is no charge to participate in this vision screening program.
3. The results of my child's individual screening will be provided to me.
4. Should the screening indicate any abnormality, a complete eye examination, and any follow-up care is the responsibility of the parents/guardian or surrogate.
5. If referred, I authorize my child's eye care professional to release the results of my child's eye exam to the child's school/facility and to the Lions Eye Health program.
6. I WILL NOT hold the Newtown Visiting Nurse Association (NVNA), Visiting Nurse organizations, the Newtown Lions Club, the Connecticut Lions Eye Research Foundation (CLERF), the Lions Eye Health program, or my child's school/facility accountable for any errors of commission, omission, or no diagnosis.

Date: _____

Signature of parent or guardian/surrogate:
_____

Phone: _____

Address: _____
_____

OPT OUT: I **do not** want my child, _____to have this eye screening.