Lions District 2-S3 Charities, Inc.

KIDSIGHT PROGRAM

Vision Screening Permission Slip

This vision screening is being offered by the _____ Lions Club.

It will be performed by Lions District 2-S3 Certified Vision Screeners. This screening provides photographic images of your child's eyes in order to detect possible vision disorders.

I understand the following regarding this program –

1 – The information obtained identifies potential vision disorders and does not constitute a diagnosis. A specific diagnosis can only be made by an ophthalmologist or optometrist, depending on the type of care needed.

2 – I understand that I am solely responsible for arranging an examination by an ophthalmologist or an optometrist if the vision screening examination so indicates.

3 - I also understand that if a possible vision problem is detected, I will receive a referral sheet with pertinent data from the screening.

4 – Photographs and/or videos taken at this screening may be submitted to the media as publicity for our KidSight program.

PLEASE PRINT CLEARLY –

Child's Name - _____

Male _____ Female_____ Date of Birth - _____

Parent/Guardian Name - _____

Parent/Guardian Signature - _____

Date - _____