CONSENT FORM
VISUAL SCREENING PROGRAM

I give permission for the below named child to participate in the free vision screening program that will be conducted at _____ on _____.

I have read and understand the following:

- Visual screenings are intended to uncover conditions that might affect eyesight. They do not constitute a medical diagnosis and are not a replacement for an eye exam by a medical professional. Not all vision problems are detected by the vision screening process.
- I understand that over 95% are successfully screened and that a few cannot be screened due to incompatibility between child and equipment.
- I will be provided with the results of the screenings.
- If the screenings indicate any possible vision problems, I am responsible for any follow up with a medical professional.
- All information will be kept confidential and will not be made available to any third parties without my written consent.

_____

Print name of parent or legal guardian

_____Date: _____

Sign name of parent or legal guardian

_____

Preferred contact information if required, e.g. phone, email, other

Child's Full Name: _____

Male ☐ Female ☐ First Middle Last Initials _____ Child wears glasses: No ☐ Yes ☐

Child's Date of Birth _____ Child s' Age _____

You may contact me after the screening regarding my child's results: No ☐ Yes ☐

For office use:

Child screened on: _____

Passed: ☐ Failed: ☐ Unable to screen: ☐