

CONSENT FORM

On \_\_\_\_\_, a free vision screening will be offered to your child. The test provides instant photographs of your child's eyes to help detect the possible presence of eye disorders, including far and near sightedness, astigmatism, strabismus (misaligned eyes), anisometropia (unequal refractive power), and media opacities (i.e. cataracts). No physical contact is made with your child and eye drops are not necessary.

I, the undersigned, have the authority to grant permission and do hereby give permission for my child, \_\_\_\_\_, to participate in the screening event. I understand the following:

1. There is no charge to participate in the vision screening process.
2. I will be contacted with the results.
3. The information obtained from this vision screening is to be considered a preliminary procedure only and does not constitute a diagnosis of vision problems, nor an eye examination. It is merely a part of a comprehensive eyecare program which includes periodic optometric/ophthalmological exams.
4. I understand that I am responsible for arranging for a full eye exam with an eyecare professional. If my child has been referred as a result of the vision screening test, I understand that it is my obligation to make such arrangements.
5. I understand that the Lions Club and any other participating organizations conducting the screening will not be held liable for any errors of commission, omission or of any other nature. I hereby waive any and all claims for liability that may arise from any occurrence as a result of this vision screening. I acknowledge notice of this waiver of liability.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child's Name    DOB \_\_\_\_\_

Age \_\_\_\_\_    Male \_\_\_\_\_    Female \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone