Consent for Vision Screening

Free vision screenings will be offered to all students at _____ School,
Name of School

in grades____ to ____ by _____ on _____.
Organization Name Date(s) of screening

Vision screening of a student's eyes will not take the place of a professional eye examination by an eye care provider. The purpose of school vision screening is to assist in detecting vision problems that may affect the student's ability to be successful in class.

No student will be screened without a signed and completed consent form. Each individual student needs his/her own consent form. If you have questions about the consent form, please contact:

_____ _____
Name of contact person Telephone number

Please print or type the information below:

Child's Name _____
First Middle Last

Parent's or Guardian's Name
_____

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

1. If your child currently wears glasses, please be sure she/he brings the glasses to school on the date of the screening event.
2. The information obtained from this screening does not constitute a diagnosis of vision problems.
3. There is no charge to participate in the vision screening event.
4. I will be contacted with the results of the screening by _____ School. For those children who receive a referral, a list of local eye care providers will be provided by the school.
5. _____ School will maintain the confidentiality of all records and results according to district policy.
6. There are no foreseeable risks to participating in the vision screening.

_____ _____
Signature of Parent or Guardian Date