



KIDSIGHT VISION SCREENING PARENT PERMISSION FORM

Signing below gives your permission for the Lions of District 2-X3 to conduct a vision screening for your child. You will receive a copy of the screening results.

I give my permission for my child to participate in the KidSight Vision Screening conducted by the Lions of District 2-X3,

On: Wednesday Oct, 30th 2019

At: Lovely Elementary for Pre-K & K only

I understand the following regarding the program:

I understand the screening identifies potential vision disorders and does not constitute a diagnosis or an examination that can only be made by an ophthalmologist or an optometrist.

- I understand that I am solely responsible for arranging any follow up that is recommended by the screening.
- I understand all information about my child is held confidential.
- I understand the vision screening is provided free of charge

Parents you do not need to be present.

Please print information clearly

Childs name: _____

Male: _____ Female: _____ Date of Birth: ____/____/____ Age: _____

Print parent/guardian name: _____

Signature of parent/guardian: _____