



Lions CLUB VISION SCREENING



Date _____

Name _____ DOB: _____

Student Number

Parent/Guardian Name _____

Address _____

Phone (H) _____
(W) _____
(C) _____

The parent or guardian will be notified in the event the results of this screening indicate the child is at risk for an ocular problem. If you are not notified the child has passed the screening.
OPT OUT Of Follow-Up Call

PASS	<input type="checkbox"/>
REFER	<input type="checkbox"/>

IMPORTANT: The Lions Club provides this screening as a community service. While the *Vision Screener* is a very sophisticated scientific, clinical instrument, it may produce both false positive and false negative results. It is intended to assist in identifying significant ocular conditions, which may lead to amblyopia (Lazy Eye). If the child passes this screening but the parent or guardian have concerns, or there is an immediate family history of amblyopia or other eye problems, the child should receive a comprehensive eye examination by an eye doctor. This screening is not intended to substitute for a comprehensive eye examination.

I have read the above disclaimer and give permission for the Lions Club to perform this screening.

Parent/Guardian Signature

Date