DPS Form

FREE Vision Screening
Colorado Lions KidSight Program

The Colorado Lions KidSight Program will offer free vision screening to your child at his/her preschool or kindergarten. The screening uses state-of-the-art technology and is 85-90% effective in detecting the vision problems that could lead to lazy eye. No physical contact is made with your child and no eye drops or medications are used. For more information visit our website at www.kidsightcolorado.org.

Is your child currently under the care of an eye doctor? ☐Yes ☐No Name of eye doctor and date of last exam _____________

WHY VISION SCREENING? *1 in 20 children has an undetected vision problem that could turn into lazy eye if left untreated. Early detection and treatment is essential to prevent lazy eye.*

Parent/Guardian: Please fill out the following. All information is kept confidential and is not sold to third parties.
PLEASE PRINT and ANSWER ALL QUESTIONS

Child's Full Name ____ [___ ___ ___] Male___ Female___
First Middle Last 3 Initials

Child's Date of Birth ____________________ Child's Age _____ School Attending ______________________________
Month Day Year

Parent or Guardian ____________________________________ Email ____________________________________

Address ____City ______________________ Zip Code __________

Phone INCLUDING area code ___________________________

CONSENT:

I hereby give permission for my child to participate in the screening event. I have read and understand the following information regarding this program:

- The information obtained from this vision screening is preliminary only and does not constitute a diagnosis of vision problems. Not all vision problems are detected by the vision screening process.
- The results of my child's screening will be sent to my child's school nurse and then distributed to me. I may be communicated with by telephone if my child does not pass the vision screening.
- I understand that if my child does not pass the eye screening, I am responsible for arranging for an eye exam with an eye doctor of my choice. I understand that I am responsible for all costs of any eye exams.
- I will not hold the Lions Organization, KidSight Colorado, DPS, or any employee, agent, officer, or representative thereof, liable for any injury which may accrue as a result of the vision screening, including but not limited to errors of commission, errors of omission or other misdiagnosis, or other misinformation.

____ ______________
Signature of Parent or Guardian Date

RESULTS: **For Office Use Only**

To be interpreted by KidSight staff and returned to school nurse within four weeks of the screening:

_____**Pass** We are unable to detect a vision problem at this time. This screening is not a substitute for a complete pediatric eye exam. Consult an eye care professional if a vision problem is suspected.

______**Borderline** Your child *may be developing* a mild refractive error that does not need to be formally evaluated at this time. We recommend the child be re-screened by an eye care professional in one year or sooner, if a vision problem is suspected.

______**Unreadable** We were unable to get reliable vision screening results for your child. This can happen occasionally if your child looks away from the blinking light during the screening. Consult an eye care professional if a vision problem is suspected.

_____**Refer** Child should be examined by an eye care professional because he/she ***may*** have the following condition:

_____ Strabismus _____ Anisometropia
_____ Astigmatism _____ High Farsightedness
_____ High Myopia _____ Other: ______________________

VOLUNTEER:

For Sure Sight Users:

*Please **TAPE** Child's Vision Screening Readout at both the **top & bottom edge** and label with **child's initials** and **date of birth***