Iowa KidSight
Consent Form

Date of Screening: _____

Is this child currently under the care and treatment of an eye doctor? ☐ No ☐ Yes, name of eye doctor/clinic: _____ City _____

If yes, the screening is not necessary and may not be conducted in order to use our limited resources for children whose vision problems have not been identified.

Free vision screening will be offered to children by a local Lions Club. Screenings are in conjunction with Iowa KidSight, under the Department of Ophthalmology and Visual Sciences at the University of Iowa Hospitals and Clinics. Vision screening produces images of a child's eyes to determine the presence of eye disorders including far- and near-sightedness, astigmatism, anisometropia (unequal refractive power), strabismus, (misaligned eyes), and media opacities (e.g., cataracts). No physical contact is made with a child and no eye drops are used during the vision screening. This screening is approximately 85-90% effective in detecting problems that can cause reduced vision.

Participation is voluntary. This screening is designed for pre-school-aged children. Children who are younger than 6-months old will not be screened. No child will be screened without a signed and completed consent form. Each individual child needs his/her own consent form. If you have questions, please contact: Iowa KidSight, University of Iowa Hospitals and Clinics, Department of Ophthalmology & Visual Sciences, 2431 Coral Court #5, Coralville, Iowa 52241, or 319-353-7616, or kidsight@uiowa.edu.

Please print or type the information below:

Child's Name _____ (_____)
First Middle Last Initials

Male _____ **Female** _____ **Child's Date of Birth** _____/_____/_____ **Child's Age** _____
(MM/DD/YYYY)

Parent's Name _____

Address _____ **City** _____ **Zip** _____

Home Phone (_____) _____ **Work Phone** (_____) _____

Cell Phone (_____) _____ **E-mail address** _____

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

1. The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision problems.
2. There is no charge to participate in the screening event.
3. I will be contacted with the results of the screening through Iowa KidSight at University of Iowa Hospitals and Clinics, or through my child care provider who aided in arranging the screening. I may be contacted by telephone regarding follow-up for vision referral by Iowa KidSight staff at University of Iowa Hospitals and Clinics.
4. This screening result may satisfy the requirement for vision screening upon entry to kindergarten, and may be recorded in the Iowa Immunization Registry.
5. I am responsible for arranging a full eye examination with a doctor of my choosing if my child has been referred as a result of the vision screening. Iowa KidSight recommends a dilated eye examination.
6. The results of your child's eye examination will be shared with Iowa KidSight as a means to help evaluate the screening program's effectiveness.
7. Iowa KidSight will maintain the confidentiality of all records and results.
8. I will not hold the Lions Club and its volunteers, Lions Clubs organizations, University of Iowa Hospitals and Clinics, or affiliates, accountable for any errors of commission, omission or other misdiagnosis. There are no foreseeable risks to participating in the Iowa KidSight vision screening.

_____ _____
Signature of Parent or Guardian **Date**