NEWTOWN LIONS CLUB
And
NEWTOWN VISITING NURSE ASSOCIATION
VISION SCREENING CONSENT FORM

The Newtown VNA along with the Newtown Lions Club will conduct a free vision screening for children in the St Rose School PK, Kindergarten, First, Third and Fifth grades. The screening equipment used may determine the presence of eye disorders including far and near sightedness, astigmatism, anisometropia, strabismus, and anisocoria. A photographic process does the screening from a distance of three feet. There is no physical contact with your child and eye drops will **not** be administered.

I, the undersigned, hereby give permission for my child, (Please print)_______________ ___________to participate in the eye screening.

Student Age ____ Male ___ Female ___ Date of Birth ____________________

I understand the following regarding this program:

1. The information obtained from this vision screening is preliminary only and does not constitute a complete exam or diagnosis of vision problems.
2. There is no charge to participate in the vision screening.
3. The results of my child's individual screening will be provided to the St Rose School Nurse.
4. Should the screening indicate any abnormality a referral by the school nurse will be made to you for follow-up by an optometrist or ophthalmologist? I authorize the eye care professional to release the results of my child's eye exam to the St. Rose School Nurse
5. I will not hold the Lions Club or Newtown VNA organizations, the Connecticut Lions Eye Research Foundation, the Lions Eye Heal Program or the school accountable for any errors of commission, omission, or any other misdiagnosis.

________ ____
Date Print and Signature of parent or guardian

________ ____
Phone # Address

I **do not** want my child, _________________________to have this eye screening.