

## Consent Form Iowa KidSight Collaborative Project Iowa Public Health Agency



Date of So	creening:				
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Agency scr and Visual of a child's anisometro No physica	eening sites. S Sciences at Ur eyes to determ pia (unequal re I contact is ma	creenings are in inversity of lower in the present fractive power in the with a child in the contractive power in the with a child in the contractive power in the contract	in conjunction with a Stead Family Chice of eye disorders b, strabismus (misa and no eye drops	Iowa KidSight, in th ildren's Hospital. Vis s including far- and i aligned eyes), and m	nity at Iowa Public Health e Department of Ophthalmology sion screening produces images near-sightedness, astigmatism, nedia opacities (e.g., cataracts). vision screening. This screening d vision.
Children wh signed and	no are younger completed cor please contact	than 6-months	s old will not be scr ch individual child	eened. No child will needs his/her own c	ge through Kindergarten. be screened without a consent form. If you have 52241, or 319-353-7616, or
Please <u>p</u>	rint or type	the informa	tion below:		
Child's Na	me				
Male	Female	First Child's Da	Last ate of Birth	// (MM/DD/YY)	Child's Age
Parent's N	ame				
Address _				City	Zip

1. The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision problems.

to participate in the screening event. I understand the following regarding this program:

2. I will be contacted with the results of the screening through Iowa KidSight at the University of Iowa Stead Family Children's Hospital, or through the Iowa Public Health Agency who aided in arranging the screening. I may be contacted regarding follow-up for vision referral by Iowa KidSight staff.

Cell Phone ( ) Other Phone ( )

- 3. This screening result may satisfy the requirement for vision screening upon entry to kindergarten, and may be recorded in the Iowa Immunization Registry.
- 4. 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 <u>dilated</u> eye examination.
- 5. 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.
- 6. Iowa KidSight will maintain the confidentiality of all records and results.

I, the undersigned, hereby give permission for my child,

7. I will not hold the Lions Club and its volunteers, Lions Clubs organizations, Iowa Public Health Agency, University of Iowa Stead Family Children's Hospital, 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.