IOWA HEALTH CARE | Stead Family Children's Hospital

Iowa KidSight
Collaborative Project Consent Form
Iowa Public Health Agency

Date of Screening:_____ **#**_____

Has this child seen an eye doctor within the last year? ☐ **No** ☐ **Yes**

(If yes, please continue appointments with your child's eye doctor.

Free vision screening will be offered to children by a local Lions Club. Screenings are in conjunction with Iowa KidSight, in the Department of Ophthalmology and Visual Sciences at the University of Iowa Stead Family Children's Hospital. Vision screening produces images of a child's eyes to determine the presence of eye disorders: 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 children 6 months of age through Kindergarten. 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 their own consent form. If you have questions, please contact: Iowa KidSight, 2431 Coral Court #5, Coralville, Iowa 52241, Phone: 319-353-7616 or email: kidsight@uiowa.edu.

Please print or type the information below:

Child's First Name_____**Last Name**_____

Female____**Male**____**Other**____ **Child's Date of Birth** _____/_____/_____ **Child's Age** _____
(MM/DD/YY)

Race/Ethnicity: ☐**American Indian** ☐**Alaska Native** ☐**Asian** ☐**Black or African American**
☐**Hispanic or Latino** ☐**Pacific Islander** ☐**White or Caucasian** ☐**Other**

Parent's Name _____

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

Cell Phone (_____**)**_____ **Other 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. I will be contacted with the results of the screening through Iowa KidSight or through the Iowa Public Health Agency who aided in arrannging the screening. I may be contacted regarding follow-up for vision referral by Iowa KidSight staff.
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 dilated 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.
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.

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