Vision Services of Washington-Greene
(Formerly the Washington-Greene County Blind Association)
566 East Maiden Street, Washington PA 15301
(724) 228-0770 (724) 228-6617 info.visioinservicesofwg@gmail.com

CONSENT FORM

Provision of Preschool Vision Screening Program

Dear Parent or Guardian:

It is important to check your child's eyes at an early age because a vision problem can be undetectable by even the most conscientious parent or guardian.

The Provision of Preschool Vision Screening Program of Vision Services of Washington-Greene will be conducting a preschool vision screening at your child's learning center on _____/_____/_____.

As the undersigned parent/guardian, I hereby grant permission to Vision Services of Washington-Greene to screen the vision of the child whose name appears below.

Child's Name _____ Birth Date _____ Sex ___M___F

Parent(s) /Guardian's Name _____ Telephone _____

Address _____

Email Address _____

Screening Site: _____

As the undersigned parent/guardian, I herby grant permission to Vision Services of Washington-Greene to screen the vision of the above-named child.

I understand that this procedure is a ***limited vision screening*** designed only to detect certain symptoms of potential vision problems in children. It is **not** a professional eye examination and is not intended to take the place of an eye examination done by an ophthalmologist or optometrist. **If a professional examination is recommended**, I give my consent to permit Vision Services of Washington-Greene to obtain information from the examining eye specialist regarding my child's eye examination and recommended treatment and to furnish such information, as needed, to the appropriate school/agency. I also understand that follow-up is required and that I may be contacted by the agency for further information.

Parent/Guardian Signature: _____ ***Date:*** _____

Has your child had a professional eye examination by an ophthalmologist or an optometrist?
Yes _____ No _____

( ) Wears glasses
( ) Squints at objects
( ) Tilts or thrusts head forward
( ) Blinks more than usual
( ) Shuts or covers one eye
( ) Complains about eyes
( ) Holds objects close to eyes
( ) Rubs eyes excessively
( )Either eye turns in, out, up or down (which one?) _____
( ) Other observations: (describe): _____

Thank you!

Date: _____ Results: _____ Initials: ___