THIS FORM MUST ACCOMPANY YOUR CHILD TO THE FREE VISION SCREENING

Member of Pennsylvania Association for the Blind

ROBERT B. GARRETT
PRESIDENT/C.E.O.

W AA A H NA O UK

DATE: ____________________

SITE: ____________________

SCR: ________ REFERRED: [ ]

FREE CHILDREN'S VISION SCREENING!

North Central Sight Services is pleased to inform you that we are scheduled to perform **FREE Vision Screenings** at your child's Day Care, Preschool, Head Start, or Kindergarten Registration. Young children do not always realize that they are having vision problems and don't always know how they are supposed to be seeing the world around them. Most eye problems do not go away as a child grows. Early detection and treatment of a diagnosed condition can yield the best results. Along with vision screenings, parents should also be alert for signs of vision problems that include frequent rubbing of the eyes, holding books and papers close to the face, squinting, excessive blinking, or tilting of the head from one side to the other. Covering one eye to favor the other, frequent appearance of sties or redness, and even watery eyes can also be signs of a vision problem.

NCSS takes pride in being able to provide the highest level of quality by using the latest technology in vision impairment detection equipment. The screening will be conducted by our highly trained staff using the Welch Allyn SPOT Screener, a camera like device that scans the eye for evidence of refraction errors and the presence of astigmatism. The scan is quick, non-invasive, stress free, and highly accurate at detecting vision problems in young children. Please fill out the attached consent form and return to your child's preschool as soon as possible. Only children with signed consent forms will be able to participate.

VISION SCREENING CONSENT AND REGISTRATION FORM

PLEASE COMPLETE IN FULL (PLEASE PRINT)

Child's Name: ______________________ **Age:** _____ **Date of Birth:** __________ **Gender:** M F

Parent/Guardian Name: ______________________ **Phone:** ______________________

Mailing Address: ______________________ **City:** __________ **State:** _____ **Zip:** __________

Email (optional): ______________________ **County of Residence:** __________ **School Dist:** __________

Known Vision Issues/Concerns: ____

Date of child's last eye exam: ______________ **(Circle One): Pediatrician or Optometrist/Ophthalmologist**

As the undersigning parent/guardian, I hereby grant permission to North Central Sight Services, Inc. to screen the vision of the above named child. If a professional eye exam is recommended, I give my consent to permit North Central Sight Services, Inc 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. In addition, 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 an eye exam and is not intended to take the place of a professional eye exam performed by an optometrist or ophthalmologist.

Parent/Guardian Signature: ______________________________ **DATE:** ______________

Occasionally, North Central Sight Services will use pictures taken during screenings and events for marketing purposes. If you wish for your child's picture not to be used in our non-profit marketing material, please initial here. ________

Office Use Only

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SE	________	SE	________
DS	________	DS	________
DC	________	DC	________

North Central Sight Services, Inc.

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