Consent Form for Vision Screening

Is this child currently under the care and treatment of an eye doctor?

❑ **No** ❑ **Yes, eye doctor/clinic** _____ **City**_____

If yes, the screening is not necessary and may not be conducted in order to use our limited resources for children whose vision problems have not been identified.

Free vision screenings will be offered to children by the Greater New Orleans Immunization Network on their mobile immunization unit. Children's Hospital is helping to coordinate the screenings courtesy of funding awarded through a grant from the Greater New Orleans Foundation. Vision screening produces images of a child's eyes to determine the presence of eye disorders including astigmatism, anisometropia (unequal refractive power), hyperopia, myopia, corneal reflexes and anisocoria. 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. Children between the age of 5 months and 21 years of age will be screened. Children who are younger will not be screened. No child will be screened without a signed and completed consent form. Each individual child needs his/her own consent form. If you have questions about the consent form, please contact: The Greater New Orleans Immunization Network, 201 Evans Road, Suite 314, Harahan, LA 70123 or (504) 733-3268.

Please <u>print or type</u> the information below:

Child's Name_____

First **Middle Initials** **Last**

Male_____ **Female** _____**Child's Date of Birth**_____ **Child's Age (in months or years)** _____

Parent's or Guardian's Name _____

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

Home Phone (_____**)** _____ **Work Phone (**_____**)** _____

Cell 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. **There is no charge to participate in the screening event.**
3. **I will be contacted with the results of the screening through the Greater New Orleans Immunization Network. For those children who receive a referral, a list of local ophthalmologists will be emailed or mailed via U.S. mail to your home address.**
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. The Greater New Orleans Immunization Network recommends a dilated eye examination.**
5. **The Greater New Orleans Immunization Network will maintain the confidentiality of all records and results.**
6. **1 will hold neither the Greater New Orleans Immunization Network or its volunteers, nor Children's Hospital or its affiliates, nor the Greater New Orleans Foundation liable for any errors of commission, omission or other misdiagnosis. There are no foreseeable risks to participating in the vision screening.**

_____ _____

Signature of Parent or Guardian **Date**