Washington-Greene County Blind Association
566 East Maiden Street, Washington PA 15301
(724) 228-0770 (724) 228-6617 Fax washgreene@onecommail.com

CONSENT FORM

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 Prevention of Blindness Program of the Washington-Greene County Blind Association will be conducting a preschool vision screening at your child's preschool on: ______/______/______

As the undersigned parent/guardian, I hereby grant permission to the Washington-Greene County Blind Association 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 ____

County ___________________ Screening Location ____

If a professional examination is recommended, I give my consent to permit the Washington-Greene County Blind Association 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 examination and is not intended to take the place of a professional eye exam.

Parent/Guardian Signature: ____ ***Date:*** ______________

Has your child had a professional eye examination previously? Yes _______ No _______
If yes, Doctor's Name: ____ Date: _______________
Address: ____
Please remember, as your child doesn't know how well he/she should be able to see, he/she will probably not complain of problems with vision. Therefore, it is very important to observe behavior patterns which may indicate eye disorders. In this respect, please indicate with an (X) if your child …..

( ) Has crossed eyes
( ) Shuts or covers one eye
( ) Holds books close to his/her eyes
( ) Becomes irritable when doing close work
( ) Tilts or thrusts head forward to see
( ) Rubs his/her eyes a great deal
( ) Seems to blink more than usual
( ) Stumbles easily over small objects
( ) Squints, frowns when looking at something closely
( ) Has red or watery eyes
( ) Other observations: ____

Thank you!

The Prevention of Blindness Program of the Washington-Greene County Blind Association is funded in part by the Office of Vocational Rehabilitation, Bureau of Blindness & Visual Services