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KidSightTM Vision Screening Consent Form

**Parents/Guardians: Please read the following, sign and return the second page of this consent form for your child’s participation in the KidSight Vision Screening Program sponsored by the Northeastern Association of the Blind at Albany (NABA).**

**Please retain this copy for your records.**

I understand the following procedures and responsibilities of this vision screening:

1. SPOT™, the photographic, vision screening device, can immediately detect a variety of different vision problems including near- and far-sightedness, unequal refractive power, eye structure problems, pupil size deviations and eye misalignment. It is a quick, easy and non-invasive process requiring no dilation drops. There is no charge for participating in a KidSight vision screening.
2. The information obtained from this KidSight vision screening is considered a preliminary vision assessment and does not constitute a vision diagnosis.
3. If a vision problem is detected, results will be provided via letter to me and to my child’s physician listed on Page Two. All medical records regarding my child’s vision results will be otherwise considered confidential.
4. If a vision problem is detected, I am responsible for arranging a follow-up examination with an eye care professional. I will contact KidSight immediately with the results of the examination as outcomes are tracked to help maintain efficacy of the program.
5. I will provide contact information changes to the KidsSight Program, (518) 463-1211 x223, as soon as possible and within four weeks of the vision screening.
6. Although it is NABA’s intention to provide an accurate vision assessment and a high-quality service, I understand that the KidSight Program will be held harmless if errors of omission or misdiagnosis occur. Only an eye care professional can make a detailed medical vision diagnosis.

Tzigane Lajeunesse LPN

(518)463-1211 ext. 223

tlajeunesse@naba-vision.org

KidSight Vision Screening Consent Form

***Please complete and return this page to the teacher/nurse/KidSight representative.***

I, the undersigned, have read Page One of this KidSight Vision Screening Consent Form and understand the procedure and responsibilities. I understand the KidSight screening is to be performed by a representative of the Northeastern Association of the Blind at Albany (NABA). I hereby give NABA my permission to screen my child and release necessary medical information to the physician listed below and/or other designated health agencies.

Signed: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian signature

**PLEASE PRINT**

*Child’s Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_ Male: \_\_\_\_\_\_ Female: \_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Wear Glasses \_\_\_\_\_\_\_

Family History of Type 1 or Type 2 Diabetes:

*Parent/ Guardian Name(s) & Relationship*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Physician’s Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_