University of Iowa Stead Family Children's Hospital

Consent Form

Iowa KidSight Collaborative Project
Iowa Head Start Program

Date of Screening: _____

Has this child seen an eye doctor within the last year? ☐ **No** ☐ **Yes**
If yes, the screening is not necessary. Continue appointments with your eye doctor.

Free vision screening will be offered to children by a Lions Club in your community at Iowa Head Start Program screening sites. Screenings are in conjunction with Iowa KidSight, in the Department of Ophthalmology and Visual Sciences at the University of Iowa Stead Family Children's Hospital. Vision screening produces images of a child's eyes to determine the presence of eye disorders including far- and near-sightedness, astigmatism, anisometropia (unequal refractive power), strabismus, (misaligned eyes), and media opacities (e.g., cataracts). 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. This screening is designed for children 6 months of age through Kindergarten. Children who are younger than 6-months old 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, please contact: Iowa KidSight, 2431 Coral Court #5, Coralville, Iowa 52241, or 319-353-7616, or kidsight@uiowa.edu.

Please print or type the information below:

Child's Name _____ (_____)
First Middle Last Initials

Male _____ **Female** _____ **Child's Date of Birth** _____/_____/_____ **Child's Age** _____
(MM/DD/YY)

Parent'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. I will be contacted with the results of the screening through Iowa KidSight at University of Iowa Children's Hospital, or through the provider who aided in arranging the screening. I may be contacted regarding follow-up for vision referral by Iowa KidSight staff at University of Iowa Children's Hospital.
3. This screening result may satisfy the requirement for vision screening upon entry to kindergarten, and may be recorded in the Iowa Immunization Registry.
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. Iowa KidSight recommends a dilated eye examination.
5. The results of your child's eye examination will be shared with Iowa KidSight as a means to help evaluate the screening program's effectiveness.
6. Iowa KidSight will maintain the confidentiality of all records and results.
7. I will not hold the Lions Club and its volunteers, Lions Clubs organizations, University of Iowa Children's Hospital, or affiliates, accountable for any errors of commission, omission or other misdiagnosis. There are no foreseeable risks to participating in the Iowa KidSight vision screening.

_____ _____
Signature of Parent or Guardian **Date**

Revised 1-2017