Consent Form

Iowa KidSight Collaborative Project
UI Sight

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 screening will be offered to children by UI Sight members in your community at local screening sites. Screenings are in conjunction with Iowa KidSight, under the Department of Ophthalmology and Visual Sciences at the University of Iowa Hospitals and Clinics. 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. Children between the age of 6 months and 48 months will be screened. Children who are younger will not be screened. Children who are older can be screened, however, there are other tests available that are designed for the verbal child who can communicate specific vision problems. 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, University of Iowa Hospitals and Clinics, Department of Ophthalmology & Visual Sciences, 2346 Mormon Trek Blvd., Ste. 2700, Iowa City, Iowa 52246, 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 (in months)_____

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. **There is no charge to participate in the screening event.**
3. **I will be contacted with the results of the screening through Iowa KidSight at University of Iowa Hospitals and Clinics, or through UI Sight members who aided in arranging the screening. I may be contacted by telephone regarding follow-up for vision referral by Iowa KidSight staff at University of Iowa Hospitals and Clinics.**
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 UI Sight members, Lions Clubs organizations, University of Iowa Hospitals and Clinics, 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**

Please print your child's name, birth date, and your name on the other side of this form (on the Result Form) as well. Thank you.

Revised 7-2011