Lions Organ & Eye Bank

District 2E2

Date: _____ Registration Number: _____

Screening Location: _____

Attach Screening Results Here

☐ Passed

☐ Referred

	RT	LT
Sph		
Cyl		

Notes:

_____
Screener

_____
Child's Name

_____
Parent / Guardian Name

_____ _____
Address Apt #

_____
City, State, Zip

Child's Date of Birth: _____

Child's Age: _____ Male ☐ Female ☐

Ethnicity: _____

Phone Number: ( ) -

Email: _____

Dear Parent or Guardian:

On the indicated date(s), Lions from District 2E2 will conduct a FREE vision screening for children between the ages of six months and fifteen years. In order to receive this service, a signature from a parent or guardian is required.

Special screening instruments will be used to determine if your child might have a vision problem. The screening takes less than five minutes. It poses no risk of harm to your child's eye. If your child shows signs of a possible vision problem, you will be advised to make an appointment with an eye care professional.

By signing this form, I consent to having my child's vision screened by a Certified Lion Screener. If my child needs to be seen by an eye care professional, I authorize the Lions to retain my contact information for follow-up purposes only.

_____
Signature of Parent or Guardian

"This project made possible through the cooperation of Lions Clubs International Foundation"

Half of all blindness can be prevented through early detection and treatment, through eye safety education and through research.