United Way of Westmoreland County

PRESCHOOL VISION SCREENING PERMISSION FORM

CHILD'S NAME_____
(**Please Print**) LAST FIRST MIDDLE

CHILD'S BIRTHDATE_____ AGE_____ SEX_____

PARENT'S NAME_____ E-MAIL_____

ADDRESS_____ HOME PHONE_____
STREET

_____ WORK PHONE_____
CITY STATE/ZIPCODE

PEDIATRICIAN OR FAMILY PHYSICIAN_____

PHYSICIAN'S ADDRESS_____

This screening is to measure how well your child can see. Suggestions will be made for follow-up and evaluation as necessary. A medical diagnosis will not be given based on this screening. We acknowledge that the physical condition of a child's eye can change. We recommend annual screenings. This screening is not a substitute for routine doctor's care and examinations.

I have read and understand the above and hereby give my permission for the above named child to participate in the Preschool Vision Screening Program. I have received a copy of the United Way of Westmoreland County's Use of Information Notice and understand that the results of this screening may be shared with teachers, health coordinators, school nurses and others as appropriate.

_____ _____
SCREENING LOCATION PARENT OR GUARDIAN SIGNATURE

_____ _____
DATE OF SCREENING DATE OF SIGNATURE