



SCHOOL _____

HOMEROOM TEACHER _____

NOTE TO PARENTS: Within the coming weeks, Sight Savers America will be conducting a **FREE** vision screening at your child's school. This screening is a method of detecting possible vision problems. It is NOT a fully dilated eye exam. If it is determined that your child has failed the vision screening, you may be contacted by a representative from Sight Savers America to discuss the screening results and ensure that your child has proper access to eye care. If your child does not have access to eye care, Sight Savers America may be able to help your child obtain the necessary exam and glasses at no cost to you. Please assist with the screening process by filling out this form and returning it back to the school. If you would like more information, please contact the school or Jennifer Williams with Sight Savers America toll-free at 1-877-942-2627 ext 235.

Please check here if you do **NOT** want your child to participate. _____

PLEASE COMPLETE BOTH SECTIONS BELOW

CHILD INFORMATION

Last Name _____	First Name _____
Please Circle: Male Female	Date of Birth _____
Has your child had an eye exam in the past 12 months with an ophthalmologist or optometrist? Yes No	
If yes, date and location _____	
Does your child wear glasses or contacts? Yes No	
If yes, please ensure that your child is wearing his/her glasses or contacts on the date of the screening.	
How old are your child's glasses? _____ Are your child's lost or broken? Yes No	
Check here if you already know your child has a serious vision problem. _____	
If yes, please explain: _____	

PARENT CONTACT INFORMATION AND CONSENT

Parent Name _____	Email _____		
Home Phone _____	Cell Phone _____	Work _____	
Address _____			
City _____	State _____	Zip _____	County _____
Parent Signature _____	Date _____		