Vision Screening Cover Sheet

Vision Screening Site Information (results of the screening will be sent back to the below address). If this was an open screening and the results need to be sent back to the home address please check here._____

Date of screening:_____
Screening site (name of center):_____
Address:_____
City & zip code:_____
Contact person at screening site (Daycare/Preschool Director):_____
If this is a Head Start please list a contact person that can be contacted to help with follow-up on referred children:_____
Phone #:_____Email Address:_____

Does the school need a separate copy of the results for their records in addition to what the parents will receive? Yes or No (please circle one)

Number of children successfully screened with a printout?_____
Number of children screened where no printout was obtained but multiple attempts were made and the child was able to look at the screening device and was participating and cooperative_____
Number of children that were not cooperative and you could not screen successfully due to movement or **not** being cooperative_____

Lions Club Information

Sponsoring Lions Club:_____
Address:_____
City & zip code:_____
Lions Club Contact at Sponsoring Club:_____
Telephone number:_____
Email:_____
Name of Person that screened the children:_____
District:_____

Please send the Consent/Result forms and Vision Cover Sheet to:

Sheila Christoff, Program Coordinator
Operation KidSight
8780 Purdue Rd., Suite 5
Indianapolis, Indiana 46268