CORNING LIONS CLUB
VISION SCREENING

Date _____

Patient Number

Name _____ DOB: _____
Parent/Guardian Name _____

Address _____
_____

Phone (H)_____
(W)_____
(C) _____

The parent or guardian will be notified in the event the results of this screening indicate the child is at risk for an ocular problem. If you are not notified the child has passed the screening.

OPT OUT Of Follow-Up Call ☐

PASS ☐

REFER ☐

IMPORTANT: The Corning Lions Club provides this screening as a community service. While the *plusoptiX Screener* is a very sophisticated scientific, clinical instrument, it may produce both false positive and false negative results. It is intended to assist in identifying significant ocular conditions, which may lead to amblyopia (Lazy Eye). If the patient passes this screening but the parent or guardian have concerns, or there is an immediate family history of amblyopia, the child should receive a comprehensive eye examination by an eye doctor. This screening is not intended to substitute for a comprehensive eye examination.

I have read the above disclaimer and give permission for the Lions Club to perform this screening.

_____

Parent/Guardian Signature Date