Lions of Michigan FOUNDATION

Project KIDsight

Dear parent, our vision screener has detected that your child might have a vision problem and should be examined by an eye care professional as soon as possible. **If your child is already being treated by an optometrist or ophthalmologist, please complete Sections 1 and 2 of this form and disregard further action related to follow-up care and additional reporting.** However, if your child is not currently being treated by an eye care professional, please complete Section 1 of this form and contact an optometrist or ophthalmologist to make an appointment for your child to have a complete eye exam.

Following your child's eye care appointment, please complete Section 3 of this form and return the form to our office. Also, please authorize and encourage your child's eye doctor to complete and return the Project KidSight Eye Doctor – Referred Child Report Form. These forms help us evaluate and improve our KidSight Program and confirm that children receive the recommended follow-up care. Reporting forms can be **emailed to info@lmsf.net** or **faxed to 517-887-6642**.

For our KidSight Program to reach its fullest potential, we must ensure that children who are referred for further testing are receiving treatment, and families that need assistance with their child's eye care needs are being helped. The support of parents and eye care professionals is instrumental to the success of Project KidSight, and we are grateful for your assistance. If you need help financially or otherwise, please contact our office or the Michigan Department of Health and Human Services at 517-373-3740 (toll free: 1-855-275-6424) to inquire about available eye care assistance programs.

SECTION 1

Lions District:	Screening Date:	3-Digit Event Code:
Reason for Referral: Myopia ☐ Hyperopia ☐ Anisometropia ☐ Anisocoria ☐ Gaze ☐ Astigmatism ☐ Unreadable ☐ Other: _____		
Child's First Name:	Last Name:	
Date of Birth:	Gender: Male ☐ Female ☐	
Parent's First Name:	Last Name:	
Street Address:		
City:	Zip Code:	
Email:	Telephone:	

SECTION 2

My child is already being treated by an eye care professional with: Eye Glasses/Contact Lenses ☐ Patching ☐ Vision Therapy ☐ Other: _____	
Parent/Guardian Signature:	Date:

SECTION 3

Exam Date:	Exam Doctor's Name:
The eye doctor believes that the KidSight referral was justified: Yes ☐ No ☐	
The eye doctor believes that the reason for the referral was accurate: Yes ☐ No ☐	
The eye doctor prescribed: Eye Glasses/Contact Lenses ☐ Patching ☐ Vision Therapy ☐ No Treatment ☐ Follow-up Care ☐ Other: _____	
Parent/Guardian Signature:	Date: