Louisiana Academic Health

CONSENT FOR VISION/HEARING SCREENING

Is this child currently under the care and treatment of an eye doctor or hearing specialist?

☐ No ☐ Yes, doctor/clinic _____ City _____

If yes, the screening is not necessary and may not be conducted in order to use our limited resources for children whose vision and hearing problems have not been identified.

Participation is voluntary. Children between the age of 5 months and 21 years of age will be screened. Children who are younger will not be screened. No child will be screened without a completed and signed consent form. Each individual child needs his/her own consent form. If you have questions about the consent, please contact: Louisiana Academic Health (504) 565-7882.

Please print or type the information below:

Child's Name _____
First Middle Last

Male ☐ Female ☐ Child's Date of Birth _____ Child's Age (in months or years) _____

Parent/Legal Guardian's Name _____

Address _____ City _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email address _____

I, the undersigned, hereby give permission for my child, _____ to participate in the screening event. I understand the following regarding this program:

1. **The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision or hearing problems.**
2. **There is no charge to participate in the screening event.**
3. **Children who FAIL their screening will receive a referral to visit a local specialist.**
4. **I am responsible for arranging a full eye examination with a doctor of my choosing, if my child has been referred as a result of the vision screening. Louisiana Academic Health recommends a dilated eye examination.**
5. **Louisiana Academic Health will maintain the confidentiality of all records and results.**
6. **I will not hold Louisiana Academic Health or its volunteers liable for any errors of commission, omission or other misdiagnoses. There are no foreseeable risks to participating in the vision or hearing screening.**
7. **I give Louisiana Academic Health permission to use my child's likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.**

_____ _____
Signature of Parent or Guardian **Date**