



Child Screening Form

Please fill out this form completely. We will only contact you if your child has a potential vision problem.

1. Child Information

First Name																				
Last Name																				
Date of Birth	M	M	/	D	D	/	Y	Y	Y	Y										

Gender: _____

Current Eyewear:
(circle all that apply)

None Glasses Contacts

2. Parent / Guardian Information: Please list at least one contact for your child.

If you do not want your child to be screened, you do not need to complete this section. Skip to section 3.

Primary Contact

Name: _____
 Relationship to Child: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 Email Address: _____
 Address: _____
 City, State, Zip: _____

Secondary Contact

Name: _____
 Relationship to Child: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 Email Address: _____
 Address: _____
 City, State, Zip: _____

3. Screening Opt- Out: Only complete this portion if you DO NOT want your child screened for vision problems:

Please initial below if you DO NOT want your child to receive a free, non-invasive vision screening. If you want your child to be screened, skip this section.

_____ NO, I DO NOT WANT MY CHILD TO RECEIVE A FREE VISION SCREENING
INITIAL HERE

4. FocusFirst Screening Result (to be completed by FocusFirst screener)

Screening Complete – Passed

Absent

Complete Eye Exam Recommended – Failed

Parent Declined Vision Screening

No Result – Camera Unable to Screen

No Result – Crying, Uncooperative, Too Young



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