Lions of Michigan FOUNDATION

Project KIDsight

Dear Parent or Guardian:

Our vision screener has detected that your child might have a vision disorder that is causing a loss of vision. However, when detected early in a child's life, many vision problems can be successfully treated by an eye care professional, and normal vision can usually be restored with eye glasses, contact lenses and, sometimes, patching.

For Project KidSight to be successful and reach its fullest potential, we must ensure that referred children are being treated and families that need assistance with their child's eye care needs are being helped. The support of parents, guardians and eye care professionals is instrumental to the success of Project KidSight, and we are grateful for your assistance.

If your child is already being treated by an eye care professional for a vision problem, please indicate such in "Section 2: Parent/Guardian – Referred Child Report & Follow-up Declaration" 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 contact an optometrist or ophthalmologist, as soon as possible, to make an appointment for your child to have a complete eye exam. If you need help financially or otherwise, please contact the Michigan Department of Health and Human Services at 517-373-3740 (toll free: 1-855-275-6424) or our office to inquire about eye care assistance programs to help your child and family.

Please authorize and encourage your child's eye doctor to complete and return the KidSight "Eye Doctor – Referred Child Report Form" to our office. The information provided by your child's eye doctor will help us validate the results of our vision screening program, confirm that your child received care and improve Project KidSight. The form may be faxed to our office at 517-887-6642.

Following your child's eye care appointment, please complete Section 2 of this form and return the form to our office. This will ensure that we receive timely proof that your child received follow-up eye care, in the event that we do not receive a report form from your child's eye doctor. This information may emailed to our office at info@lmsf.net or faxed to 517-887-6642.

SECTION 1: Referred Child Information

Date: _____ KidSight Project Number: ___ ___ ___ ___ - ___ ___ ___

Reason for Referral: Anisometropia ____ Anisocoria ____ Astigmatism____ Myopia____ Hyperopia____
Gaze Deviation____ Unreadable____ Other_____

Child's Name: First_____Middle_____Last_____

Date of Birth: _____ Gender: Male ____ Female ____

City: _____ Zip Code: _____ County: _____

Parent/Guardian's Name: First_____Last_____

Telephone: _____ Email: _____

SECTION 2: Parent/Guardian – Referred Child Report and Follow-Up Declaration

____ My child is already under the care of an eye care professional. He/she is currently being treated with:
Eyeglasses ____ Contact Lenses ____ Patching ____ Vision Therapy ____ Other_____.

My child was examined on _____ by an eye care professional at: _____.

The eye care doctor believes that the KidSight referral was justified: Yes ___ No ___

The eye care doctor believes that the reason for the referral was accurate: Yes ___ No ___

The eye care doctor prescribed: Eye Glasses/Contact Lenses ____ No Treatment ____ Patching ____
Vision Therapy ____ Follow-up Care ____ Other (Explain) _____.

Signature: Parent/Guardian: _____ Date: _____