



Multiple District Health Service Board

NOTICE

**All Operation KidSight vision screening must be sent to
Lion Sandra Hill
45 Whitten Road
Milford, NH 03055**

**If your club has not received notification of the test results within three
(3) weeks, please call Sandy at (603) 673-8075.**

**If you need any further assistance please call the Health Service Board
President Bob Laferriere (603) 329-8230 or
IPP VDG Celeste Ricupero (603) 521-7757**



Dear Club Operation KidSight Coordinator,

We continue to have difficulty processing the OKS paperwork; the hand writing is often illegible. We really need your help in proof reading the paperwork before sending it to the OKS Coordinator to ensure the information is clearly printed and signed. Without your help it will delay the process and negatively impact the children needing a referral to a doctor/specialist.

- (1) Be sure each parent or Guardian receives the results notification letter, prior to the screening. (Form 2)
- (2) Be sure the print out is attached to the paperwork.
- (3) Be sure the paperwork is sent to our OKS Administrator within two days.

The **KidSight** program needs your support, by screening as many children from the ages of **6 Months to 6 years...**

All Donations can be sent to:

Health Service Board
C/o Marilyn Vaccaro Secretary/Treasurer
74 Chase Road
Londonderry, NH 03053

Checks should be made out to HSB, with OKS in memo area.

The SureSight Camera is for screening 6 months to 6 year old children ONLY

There is a \$2.00 charge for ALL children screened. Over six years these screenings will NOT be read by the OKS doctors.

School age children from 6yrs and above should be screened on the Titum camera. You may also screen any adult on the Titum.

The Health Service Board of Directors would like to thank you for your continuing support.

(Form 1)



{Name, Address, Phone Number of Lions Club Point of Contact}

Dear Parent or Guardian:

On _____, **Operation KIDSIGHT**, sponsored by the New Hampshire Lions, will offer free vision screening for your child at _____. The screening involves a **Welch Allyn® SureSight™ Vision Screener** that can be used to determine the presence of eye disorders including: far and near sightedness, astigmatism, strabismus (misaligned eyes), anisometropia (unequal refractive power), and media opacities (cataracts). No physical contact with your child is necessary and no eye drops will be used. This screening is approximately 87% effective in detecting problems that can cause decreases in vision.

To participate in this free screening, you must complete the following Consent Form for each child to be screened. Please list only one child per Consent Form. This Consent Form must be returned by _____ in order to participate.

CONSENT FORM

I, the undersigned, am the parent or legal guardian for _____ and give my permission to participate in the screening event. I agree to the following:

1. There is no charge to participate in the vision screening process.
The information obtained from this vision screening is to be considered a preliminary procedure only and does not constitute a final diagnosis of vision problems.
3. You will be notified following the screening interpretation within 3 weeks **ONLY** if the child has a problem.
4. I understand that I am responsible for arranging for a full eye exam, either with my own doctor or through the Lions Club, if my child has been referred as a result of the screening.
5. I understand that the organization conducting the screening will not be held accountable for any errors of commission, omission or other misdiagnosis.

Parent or Guardian Signature

Date of Signature

Printed Parent or Guardian Name

Please fill in Screening Information on the Reverse

Operation KIDSIGHT Mission: To prevent blindness through early detection and treatment of the most common vision disorders in pre-school children.



Dear Parent or Guardian,

Your child will be tested today with the Welch Allen SureSight™ Vision Screener.

This screener automatically screens for common vision problems, including nearsightedness (myopia) and farsightedness (hyperopia), astigmatism (asymmetrical focus) and anisometropia (unequal power between eyes).

An Eye Physician will check the results of this screening. If your child needs a referral our Program Administrator will call you within three (3) weeks of this test.

You will **NOT** receive a call if your child **passed this screening.**

If you need any further information on our KidSight Program please contact

Bob Laferriere Res: 603-329-8230 E: f.laferriere@comcast.net

Tom Reynolds Res: 603-529-0042 E: tcreynoldsjr@comcast.net

Operation KidSight Administration Procedures

- ◆ Once the vision screening print outs are received from club, they should be listed and passed on to the Doctor for readings within two (2) days
- ◆ The Doctor will send the results back once completed
- ◆ If there is a referral, a call Must be made to the parent, with the Doctors finding. Explain to the parent that you will call in approximately Four (4) weeks as a follow up.
- ◆ List the date, time and parents name, for your records and any notes you may feel are important from the conversation.
- ◆ Send a letter to the club notifying them of the results, within three – four days after receiving results from the doctors
- ◆ File all records
- ◆ A monthly report is to be done for the Health Service Board Directors
 - (A) Name of Club doing the testing
 - (B) Number tested
 - (C) Number passed
 - (D) Number of referrals
 - (E) Date of testing
 - (F) Date of receiving testing from club
 - (G) Date sent to Doctor
 - (H) Doctor doing the readings
 - (I) Date readings returned from Doctor
 - (J) Date letter sent to club
 - (K) Date of referral call

These Procedures are effective as of June 8, 2008