Success Story Questionnaire

Please share how Prevent Blindness Wisconsin has made a difference in your child's life! If you submit a photo of your child wearing their new glasses or patching, they can receive one of the following books (please choose one):

- ☐ Jacob's Eye Patch
- ☐ My Bright Blue Glasses
- ☐ Fancy Nancy: Spectacular Spectacles
- ☐ In the Tall, Tall Grass
- ☐ I Spy in the Sky

Child's Name: _____ Age _____ Parent's Name: _____

Address:_____City_____State_____Zip_____

Phone Number: _____ E-mail address: _____

Child's School, Preschool, Head Start, or Childcare Center: _____

Did your child receive a vision screening? ☐ Yes ☐ No Does your child wear glasses? ☐ Yes ☐ No

Is your child undergoing other treatment (e.g. patching) for a vision or eye health problem? ☐ Yes ☐ No

If yes, please explain: _____

Please answer the following questions. If you run out of space, please continue on the back of this form.

1. How has a vision screening helped your child?

_____

_____

_____

2. Did you ever suspect your child had a vision problem? Why or why not?

_____

_____

3. How does your child's diagnosis make you feel?

_____

_____

4. How has your child changed since they started wearing glasses/receiving treatment?

_____

_____

_____

5. How does your child feel about wearing glasses/receiving treatment?

_____

_____

Permission to use Photographs and / or Written Materials

By submitting this application, I give Prevent Blindness Wisconsin and Prevent Blindness permission to use my child's story and photo in any promotions, advertisements, publications, and more, as seen fit by Prevent Blindness Wisconsin.

Parent/Guardian Signature: _____ Date: _____

Please return to: Prevent Blindness Wisconsin ● 731 N. Jackson Street, Suite 405 ● Milwaukee, WI ● 53202
Office: (414) 765-0505 ● Fax: (414) 765-0377 ● info@pbwi.org