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 will receive a **FREE** vision related book.

Child's Name: ______________________________ Age: _____ Parent's Name: ___________________
Address:____
Phone Number: _________________________ E-mail address: _________________________________
Child's School, Preschool, Head Start, or Childcare Center: ______________________________________

Exam Results: ☐ Normal ☐ Amblyopia ☐ Strabismus ☐ Refractive Error ☐ Hyperopia ☐ Myopia ☐ Astigmatism ☐ Other:

Treatment: ☐ Glasses ☐ Patching ☐Other: ____

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

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

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____

3. How has your child changed since they started wearing glasses/receiving treatment?____
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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
Fax: (414) 765-0377 ● Amelia@pbwi.org