Dear Parent/Guardian,

VISION SCREENING PARENTAL PERMISSION SLIP
For Students at Ryde Public School

Over 80% of what children learn is processed through their eyes.

Free vision screening is being offered to all students at Ryde Public School. The screening looks at basic visual abilities, such as clarity of vision, the ability to coordinate both eyes as a team and eye movement proficiency. The screening will follow a protocol developed by the Optometrists Association of Australia. However, please note that the screening is not a full eye examination but is a useful guide to assess if your child may have vision problems that require further attention.

A report on the results of the screening will be prepared and given to your child at the completion of vision screening. The school will then send the report home with your child.

If an apparent problem is identified, we will recommend that you seek further assessment from your local optometrist or ophthalmologist.

Screening will be available at the school on Monday 1st and Tuesday 2nd September and is provided as a goodwill community service by a local independent optometrist who also specialises in children’s vision. It is a great community service provided at no cost to parents or the school.

If you would like your child to participate in this vision screening program, please complete the permission slip below and return this letter to your child’s class teacher.

Yours sincerely,

Margaret Lam B Optom UNSW (OAA, CCLSA, OSO, IAO)
Screening CHILDREN’S OPTOMETRISTS:

Margaret Lam, Carina Trinh, Bendy Ng, Wendy Yeung and Griffin Ngo
B Optom UNSW (OAA, CCLSA, OSO, IAO)

theeyecarecompany
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Devlin st, Ryde NSW 2112 <ph> 9808 2223
www.theeyecarecompany.com.au

To Margaret Lam,

I ........................................................................ (Parent or guardian’s name) am the parent or legal guardian of .......................................................... (Child’s name) and consent to and authorise you to perform a vision screening on my child, at Ryde Public School.

I acknowledge that the screening is not a full eye examination and that the screening is unlikely to identify every problem which a full eye examination might identify.

Signature of parent or legal guardian: ...........................................................
Name of parent or legal guardian: ...........................................................
Relationship to child: ........................................................................ Date ................................
Vision Screening Questionnaire

Over the next few weeks, the children at Ryde Public School will be having their vision screened at school. To ensure that your child is included in this important health check, please answer the questions below and return this form, along with the signed permission slip, to the school as soon as possible.

<table>
<thead>
<tr>
<th>PERSONAL INFORMATION</th>
<th>First name</th>
<th>Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male / Female</td>
<td>Class</td>
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1. LAST EYE TEST

When did your child last have their eyes examined by an optometrist or ophthalmologist?

- [ ] Less than 1 year ago
- [ ] 1 to 2 years ago
- [ ] More than 2 years ago
- [ ] Never

2. SPECTACLES?

Does your child wear spectacles (or contact lenses)?

- [ ] No
- [ ] Yes – all the time
- [ ] Yes – for looking in the distance only (school board, television etc.)
- [ ] Yes – for reading only
- [ ] Yes – sometimes Please specify

3. HISTORY

Has your child ever had any of the following conditions?

- [ ] A squint (one eye turns in or out)
- [ ] A lazy eye (one eye is significantly weaker than the other)
- [ ] Any form of eye disease (other than minor infections or hayfever)

4. FAMILY HISTORY

Does anyone in the child’s immediate family –

- [ ] Wear spectacles (or contact lenses) other than just for reading?
- [ ] Have a squint or one eye that turns in or out?
- [ ] Have a lazy eye (one eye is significantly weaker than the other)?
- [ ] Suffer from any serious eye disease (please specify below)?

5. SYMPTOMS

Does your child –

- [ ] Have any problems seeing in the distance, for example seeing the board from the back of the classroom?
- [ ] Have any problems seeing to read up close, i.e. do the words go blurred or doubled?
- [ ] Suffer from frequent headaches (two or more per week)?
- [ ] Have any other problems with their eyes that you think that we should know about? Have any attention or concentration issues that you feel may be related to the eyes? (please specify below)

6. OTHER INFORMATION

Please add any other information here