North Middlesex University Hospital NHS
NHS Trust

ORTHOPTIC (EYE) CLINIC
HORNSEY CENTRAL HEALTH CENTRE
151 PARK ROAD
HORNSEY
LONDON
N8 8JD
anu.peter2@nhs.net

Dear Parent/Guardian

VISION SCREENING OF RECEPTION CLASS CHILDREN

As part of the School Health Surveillance programme your child will have an eye test by a specially trained person (Orthoptist) carried out this term.

If for any reason you **do not** wish your child to have this test please complete the slip below and leave it with the school secretary.

Please also let the school welfare know if your child has had any eye problems in the past or is currently having treatment.

After the test, you will only be contacted and sent an appointment if your child requires **further testing** or **did not pass** the vision screening test.

Please be aware that your contact details including address and telephone number will be requested from the school should your child fail or be absent on the day of testing.

If you would **prefer not** to have your details disclosed, please complete the form below and return it to your child's teacher, so that we know to **not** test your child.

Yours faithfully

Miss Anu Peter BSc (Hons)
Senior Orthoptist

PLEASE ONLY RETURN SECTION BELOW IF YOU DO NOT WISH YOUR CHILD TO HAVE AN EYE TEST OR YOU ARE NOT HAPPY TO HAVE YOUR CONTACT DETAILS SHARED WITH US.

I **DO NOT** wish my child to have an eye test at school or for my contact details to be disclosed.

Child's name ……

Class ……

School ……..

Parent/Guardian signature……