

ORTHOPTIC (EYE) CLINIC  
HORNSEY CENTRAL HEALTH CENTRE  
151 PARK ROAD  
HORNSEY  
LONDON  
N8 8JD  
[shakilpatel@nhs.net](mailto:shakilpatel@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 team know if your child has had any eye problems in the past or is currently having treatment.

Please note that we will also be requesting your full address and contact information from the school but only if your child has **failed the eye test or is absent**.

This is so that we may get in touch with you and invite you for a re-test here at the clinic.

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.

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

Mr Shakil Patel BSc (Hons), PG Dip Ophth  
Highly Specialised 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 for my child to have an eye test at school or for my address or child's details to be disclosed.

Child's name .....

Class .....

School .....

Parent/Guardian signature.....