|  |  |  |  |
| --- | --- | --- | --- |
| **Enhanced Vision Screening Program**  Consent Form |  | | |
| Dear parent/guardian,  In Nova Scotia, Public Health screen children’s vision in grade primary. This program was developed with the IWK hospital. Eighty percent of children’s learning at this age is visual. A child is unlikely to complain about poor vision, especially if the problem is only in one eye. Catching problems early increases the chance of improving vision before children start having difficulties in school.  The screening takes 5-10 minutes. It consists of the child matching or naming symbols while wearing an eye patch. It also involves the child using 3-D glasses to see and pick shapes from a book. *If your child wears glasses, please ensure he/she has them during the screening*.  All children should be screened, even if your child wears glasses or has seen an eye doctor. However, if your child is in the regular care of an eye doctor **and** has been examined in the last 6 months, he/she does not need to be screened.  This screening does not replace a regular exam with an eye doctor. An eye exam every two years is covered by MSI until your child’s 10th birthday. An eye doctor can be found by calling 902-435-2845 or looking online at <http://www.nsoptometrists.ca>.  If you have any questions, please contact Public Health at  902-481-5800.  Thank you,  Public Health Services | 1. **SCHOOL INFORMATION** | | |
| **Where is your child registered or planning to be registered?** | | |
| **What school is your child planning to attend in September (if different from above)?** | | |
| 1. **CHILD INFORMATION** | | |
| **Last Name** | | |
| **First Name** | | |
| **Date of birth** *(year/month/day)* | | **Health Card #** |
| **Do they wear prescription glasses?**  ❒Yes ❒No | | |
| 1. **PARENT/GUARDIAN INFORMATION** | | |
| **Last Name** | | |
| **First Name** | | |
| **Home Telephone #** | | |
| **Cell/Work Telephone #** | | |
| **Postal Code** | | |
| 1. **CONSENT** | | | |
| **Do you want your child to have the vision screening?** *Please mark with an “ X “*  ❒ **Yes, I want my child to be screened.**  The results of the screening will be sent home. If there is a concern, Public Health will contact you.  ❒ **No, I do not want my child to be screened.** Please specify:  ❒Child is in care/treatment with an eye doctor or at the IWK **and** has been examined in the last 6 months  ❒Vision screening completed at another school/daycare \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of school/daycare)  ❒Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **5. SIGNATURE** | |  | |
| **Signature of parent/guardian** | | **Date** | |

***To be completed by Public Health staff only***

***Zone***: ❒ Central

***CHB***: ❒ Chebucto West ❒ Halifax Peninsula ❒ Cobequid ❒ Dartmouth

❒ South Eastern ❒ West Hants ❒ Eastern Shore Musquodoboit

***Consent received***: ❒ Verbal ❒ Written

***Child screened***: ❒ Yes

❒ No – Parent does not provide verbal consent

❒ No is indicated on the consent form

❒ No – Client has been screened within previous 6 months and is in care

❒ No - Incapacity

***Screener name***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Screen date*** (yy/mm/dd): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Time of screening*: \_\_\_\_\_\_\_\_\_\_

***School board***: ❒ Annapolis Valley ❒ CSAP ❒ Chignecto Central

❒ Halifax ❒ Home schooled ❒ Private schools

***School name*** (see reverse side, Box #1, 2nd question “School planning to attend in September”)

***Does child wear glasses*:** ❒ Yes ❒ No

***Child screened with glasses*:** ❒ Yes ❒ No ❒ N/A

*Child’s name*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Date of birth*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(yy-mm-dd)**

*Location of screening*: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Visual Acuity*:**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Right eye*** | ***Left eye*** | ***Randot*** |  |
| ***Chart line Deviation***  ❒ + 2  ❒ + 1  \_\_\_\_\_\_\_\_❒ 0  ❒ - 1  ❒ - 2 | ***Chart line Deviation***  ❒ + 2  ❒ + 1  \_\_\_\_\_\_\_\_❒ 0  ❒ - 1  ❒ - 2 | ❒ Pass  ❒ Fail  ❒ Incomplete | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  *Screener’s signature* |

***Comments*** (to be entered in database)**:**

❒ Never had prior eye exam ❒ TC parent re: outcome

❒ Incapacity ❒ Child had difficulty concentrating ❒ Child refused

❒ Referral given/sent home (circle one)

❒ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*PH staff notes* (**not** to be entered in database)

❒ TC Parent/guardian re: results (Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Time \_\_\_\_\_\_\_\_; Tel # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

❒ Spoke with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/guardian’s name)

❒ No answer; message left with PH staff’s name and telephone number

❒ Unable to reach parent/guardian (specify below)

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**