The Shrewsbury and Telford Hospital NHS
NHS Trust

Orthoptic Department
The Royal Shrewsbury Hospital
Mytton Oak Road
SHREWSBURY
Shropshire
SY3 8XQ

Monday 27th February 2023

Dear Parent or Guardian

Re: Vision Screening for Reception Children (Class 1) – Tuesday 7th March

As part of national guidelines it is required for orthoptists to carry out a routine eye test on children who are in reception class. I would be grateful for the opportunity to explain the screening programme to you.

Orthoptists are specially trained to test children's eyes, treat squints and lazy eyes etc. The tests are short simple matching games with letters which will include the wearing of a pair of glasses with one eye covered, in order to test the vision of the other eye.

It is important that eye defects are detected before a child is 6 years old. We hope you will be willing to have your child's eyes tested.

If you agree to your child being screened you DO NOT need to take any action
Your child will be tested in school.

Should you wish to have your child excluded from the eye test I would be grateful if you would complete the enclosed form and send it back to school within 7 days. A copy of the Opt Out consent form will be sent to your G.P for their records.

If your child fails their eye test the school will provide us with your contact details and you will be contacted via a letter sent by post. If your child passes the eye test we will not contact you.

If you have any questions regarding the eye test please contact your school.

Yours faithfully

Sue Vaggers

Sue Vaggers
Senior Orthoptist – School Vision Screening Lead

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Vision Screening for Reception Class Children - Opt Out

You only need to complete and return the form to school if you do not wish for your child's vision to be tested – please return by **Friday 3rd March**

DO NOT complete this form if you wish for your child to have a vision test at school.

Tick One

☐ I **DO NOT** wish my child to have a routine eye test at school

☐ I **DO NOT** wish my child to have a routine eye test at school because my child is already receiving treatment for their vision.

Name of child:	
Date of Birth:	
Address:	
G.P. Practice:	
Date:	
Signed:(Parent/Guardian)	