

Special School Eye Care Service

SERVICE PARTICIPATION & OPT-OUT

Dear Parent/Carer

The free service described in the Service Information Sheet and [Service Film](#) is **OPT-OUT**

This means
**YOU NEED TO LET US KNOW IF YOU
DO NOT WANT YOUR CHILD TO RECEIVE EYE CHECKS**
from the Special School Eye Care Service Team

If you wish to **Opt-Out**, please go to **SECTION 2** below having ensured you have first read the Information Sheet and watched the Service Film before making a choice.

If you would like your child to receive eye checks, please read the additional information in **SECTION 1** and complete the attached questionnaire, **About My Child's Eyes.**

SECTION 1

I WOULD LIKE MY CHILD TO RECEIVE THIS FREE SERVICE

ABOUT MY CHILD'S EYES FORM

Before every child's first appointment, the Eye Care Team will need to have as much information that is known by you, the parent/carer, about your child's eyes and health history. This is to ensure that the service is tailored to your child's specific needs and delivered in a way that is as comfortable and anxiety-free as possible. **If your child is already receiving regular eye care**, please indicate in the About My Child's Eyes questionnaire to let us know where they are being seen.

Please return the completed **About My Child's Eyes** questionnaire to the school for the attention of the Eye Care Service Coordinator ASAP.

INFORMATION SHARING

SCHOOL

To deliver the Special School Eye Care Service, the school will need to share your contact details and information about your child with the Eye Care Team. They may also share other information which will enable the team to provide the best care for your child. This may include health information or other information which is relevant to your child's general health and wellbeing.

EYE CARE TEAM

The Eye Care Team will **always** share the Eye & Vision Examination Results Report with you after your child's appointment. This will explain your child's eye and vision needs: for example, whether or not they need glasses, if there are any problems with their eyes and if so, how this may affect them, and what can be done to help. It will also include advice and guidance on what can be done to help them get the most from their vision.

The Eye Care Team may need to share your child's information with other healthcare and education professionals. This may include your child's GP or a hospital clinician where a referral is required and the Eye Care Team will keep you, the parent/carer, informed. They will also share information from the Eye & Vision Examination Results Report with the school team to enhance the approach taken where a child has a visual problem.

There may be occasions where additional tests are required and if so, the Eye Care Team will contact you and obtain specific consent where appropriate, eg. your child may need to have drops in their eyes.

CAN I OPT-OUT AT A LATER DATE?

Your child will continue to receive regular eye care from the Special School Eye Care Service which may include, for example, checking how well they can see, checking their eyes are healthy, prescribing glasses, regular checks to make sure the glasses are fitting comfortably, glasses repairs/replacements and regular eye tests as required.

You can opt-out your child from the service at any time by informing the school and/or the Eye Care Team.

KEY CONTACTS

SCHOOL EYE CARE SERVICE COORDINATOR	Cheryl Wilde cwilde@pchs.lancs.sch.uk
EYE CARE TEAM	Bill Reed - Kasbil@mail.com Kasim Mahmood - k451m2000@hotmail.co.uk

SECTION 2

I DO NOT WANT MY CHILD TO RECEIVE THIS FREE SERVICE

This NHS service is **opt-out** which means you need to let us know if you **do not** want your child to receive eye checks. Please ensure you have first read the Service Information sheet and watched the short NHS film [here](#) before making a choice. **If you opt-out, you are able to change your decision at any point after the time of returning this form.**

If your child is already receiving regular eye care from a hospital or other provider, the Eye Care Team will not need to see them in the school. However, if you have opted-out and your child is discharged from hospital care, for example, please contact the School Eye Care Service Coordinator if you wish your child to receive this service. You can choose at any time who you want your child to receive eye care from and where, by talking to your current provider about the options available to you.

To opt-out, please tick the check box and complete the table below, then return this form to the school for the attention of the School Eye Care Service Coordinator.

- Please tick/click this box if you **DO NOT** want your child to receive eye care checks in school from the Special School Eye Care Team

My child is already receiving eye care from:	
Date last seen	
Signature of Parent/Carer	
Print name	
Child's Name	
Relationship to child	
Today's date	

Please return the completed **About My Child's Eyes** questionnaire to the school for the attention of the Eye Care Service Coordinator ASAP.

KEY CONTACTS:

SCHOOL EYE CARE SERVICE COORDINATOR	Cheryl Wilde
EYE CARE TEAM	Bill Reed, Kasim Mahmood

ABOUT MY CHILD'S EYES

Introduction

This form will provide valuable information to the NHS England Special School Eye Care Team to ensure they can:

- make the eye test and dispensing of glasses (if required) a positive experience for your child
- understand what is already known about the eye health and vision of your child
- receive other information about your child that will help them provide the best possible service.

We will be asking questions in the following categories:

- Your Child's Details
- Your Details
- The Eye Test (Part 1)
- Eyecare History: Visits to the Optician / Visits to the Hospital
- Glasses
- Other Eye Information about your Child
- Other Health Information about your Child
- Eye Information about your Family
- The Eye Test (Part 2)
- 5 Key Questions

Completing the form

Not everything in this form will be relevant to your child but the more information you provide, the more we can tailor the service to your child's specific needs.

Where answer options are provided, please click on to indicate your choice.

Returning the form

When completed, please return this to the school using the details on the Service Participation and Opt-Out form **by the date indicated**.

ABOUT MY CHILD'S EYES

Child's Full Name	
Today's Date	

Your Child's Details

Address & Postcode	
Phone Number	
Date of Birth	
Ethnicity *	
Name of Child's GP	
GP Practice Address	

* Please see last page for options

Your Details


Full Name	
Address & Postcode	
Phone Number	
Email Address	
Relationship to Child	

The Eye Test (Part 1)

See also Part 2

If any of the following are applicable, it would be useful for the Optometrist and Dispensing Optician to see these at the eye test:

- your child's glasses
- the prescription from your child's last eye test
- your child's Education, Care and Health Plan or personal records


<p>Would you like to attend your child's first Eye Test at the school?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<p>If Yes – please bring with you the three items mentioned above if available</p> <p>If No – please arrange for the school to have these prior to the appointment if available</p>	
<p>I am happy for the Optometrist to put drops in my child's eyes.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> I would like to speak to the Optometrist first</p> <p><i>These drops, also known as Cyclopentolate, help the Optometrist to see into the eye through the pupil. They may sting a little and vision may be blurry for a short time. Side effects are extremely rare.</i></p>	

Eyecare History: Visits to the Optician


<p>Has your child ever had an eye test at the Optician/Optomertist?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <i>If No/Don't Know, go to next section</i>
<p>If yes, Name and address of current Optician/Optomertist?</p>	
<p>Date of last check</p>	
<p>Date of next check</p>	
<p>Can the Eye Care Team contact the Optometrist to access your child's eye history?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p><i>Access to previous records can help the Eye Care Team provide a better service for your child</i></p>	
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Eyecare History: Visits to the Hospital


<p>Has your child ever been to the Eye Clinic in a Hospital?</p> <div style="display: flex; align-items: center; justify-content: center;">  </div>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <i>If No/Don't Know, go to next section</i> </p>
<p>If yes, what was the problem?</p>	
<p>Name of the Hospital visited</p>	
<p>Date of last appointment</p>	
<p>Date of next appointment</p>	
<p>Did your child have an operation on their eyes?</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know </p>
<p>Can the Eye Care Team contact the Hospital to access your child's eye history?</p> <p><i>Access to previous records can help the Eye Care Team provide a better service for your child</i></p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know </p>


Glasses

<p>Has your child been prescribed glasses either by an Optician or from the Eye Clinic at a hospital?</p> <div style="display: flex; align-items: center; justify-content: center;">  </div>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <i>If No/Don't Know, go to next section</i> </p>
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Has your child been given a patch for their glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Is your child using their glasses now?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Does your child have any problems with their glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
If yes, please describe	

Other Eye information about your Child

Is your child registered blind / severely sight impaired? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Is your child registered partially blind / severely sight impaired?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Do your child's eyes always appear straight?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Don't know
If one or both eyes appear to wander, which eye does this?	<input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Both eyes <input type="checkbox"/> Not applicable
How often does this happen?	_____
Do your child's eyes appear to move excessively rapidly or uncontrollably?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Do you think your child has trouble controlling their eye movements?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
If yes, please give details:	
Does your child tend to shut one eye?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Does your child appear very sensitive to bright lights? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Does your child complain of headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Do you generally have concerns about your child's eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
If yes, please describe:	

Other Health information about Your Child

Does your child use a wheelchair? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Does your child have any health problems or disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
If yes, please describe them:	
Does your child take any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
If yes, please list them: (please take information about the medication to the eye test) 	
Does your child have any allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
If yes, please list them:	
Please give details of any difficulties during the pregnancy or child's birth:	

(eg. mother had infection, prematurity, low birth weight, need for special care, etc)	
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Eye Information about your Family

Has anyone in your family had eye problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<i>For example, did anyone wear glasses as a child, had a squint (strabismus), a patch over an eye, or an eye condition?</i>	
If yes, please describe which family member in relation to yourself had the problem and what the problem was?	
WHO	WHAT PROBLEM

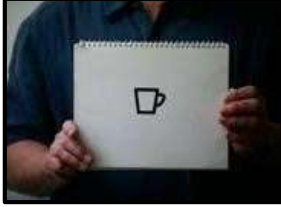


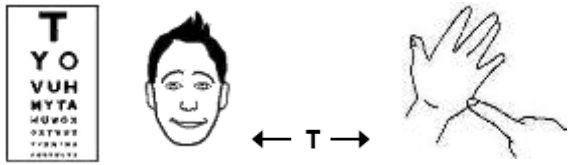

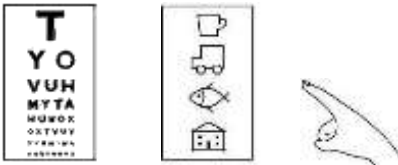
The Eye Test (Part 2)

When your child has their eye test, the Optometrist will need to:

- look at their eyes
- do some tests to check how well they can see

The information you give below will help the Optometrist to test your child's eyes and communicate with them effectively.

<p>Will your child be alright if the Optometrist comes close to them and shines a bright light in their eyes?</p> <p><i>This is done with an instrument called a Retinoscope.</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know?</p>	
<p>Will your child be alright if the Optometrist was to cover their eyes one at a time?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

<p>Can your child understand better or worse?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know?</p>	<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">  Better </div> <div style="text-align: center;">  Worse </div> </div>
<p>Will your child be able to wear test frames on their face?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	
<p>Can your child say or sign the names of letters on any Eye Test Chart?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	
<p>Can your child say or sign the names of pictures on a chart (like <i>house, fish, car</i>)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	
<p>Can your child point to a letter or picture on a card that is the same letter or picture on a chart on the wall?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	
<p>Is your child deaf or hard of hearing?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	
<p>If yes, please give more detail</p>	
<p>Does your child find it hard to communicate?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes</p>	
<p>Please indicate if your child uses any of the methods below to communicate and describe any other ways you might communicate with your child if appropriate?</p>	
<p>Makaton <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Other ways:</p>

An interpreter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pictures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gestures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

5 Key Questions

These questions may not be applicable to your child but are used to help us identify if they might have problems with their vision that are due to their brain rather than their eyes (known as CVI – cerebral visual impairment).

<p>1 Does your child have difficulty walking down stairs?</p> <p> <input type="checkbox"/> Never applicable <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always <input type="checkbox"/> Not applicable </p>
<p>2 Does your child have difficulty seeing fast-moving objects?</p> <p> <input type="checkbox"/> Never applicable <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always <input type="checkbox"/> Not applicable </p>
<p>3 Does your child have difficulty seeing something that is pointed out in the distance?</p> <p> <input type="checkbox"/> Never applicable <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always <input type="checkbox"/> Not applicable </p>
<p>4 Does your child have difficulty locating an item of clothing in a pile of clothes?</p> <p> <input type="checkbox"/> Never applicable <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always <input type="checkbox"/> Not applicable </p>
<p>5 Does your child find copying words or pictures time-consuming and difficult?</p> <p> <input type="checkbox"/> Never applicable <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always <input type="checkbox"/> Not applicable </p>

Finally , is there any other information about your child the Optometrist may need to know?	
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Thank you very much for detailing as much information as possible.

This will help the visiting NHS Eyecare Team to provide the best eye care possible for your child.

Ethnicity options

This information allow the NHS to measure and improve access, experiences and health outcomes for all patients from all communities.

Please choose one to fill in the ethnicity box.

White

English, Welsh, Scottish, Northern Irish or British
Irish
Gypsy or Irish Traveller
Any other White background

Mixed or Multiple ethnic groups

White and Black Caribbean
White and Black African
White and Asian
Any other Mixed or Multiple ethnic background

Black, African, Caribbean or Black British

African
Caribbean
Any other Black, African or Caribbean background

Asian or Asian British

Indian
Pakistani
Bangladeshi
Chinese
Any other Asian background

Other ethnic group

Arab
Any other ethnic group

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