Vision Screening & Privacy Consent Form

Instructions for Parents when completing a paper consent

1. **Read the Parent Information form first.**
2. **Fill out and sign the consent form.**
3. **Place the form in an envelope and seal the envelope.**
4. **Write your child's name and class on the envelope.**
5. **Write 'Vision Screening Consent Form' on the envelope.**
6. **Return it to your child's school as soon as possible.**
7. **For further information, please contact the Primary School Nurse Health Readiness Program on 1800 687 372.**

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Queensland Government

Primary School Nurse Health Readiness Program

Vision Screening & Privacy Consent

School: Class:

QChild ID no:

(Affix patient identification label here)

OFFICE USE ONLY

1. Child's Details (please complete in BLOCK letters using **black** pen)

Child's family name: Child's given names:

Preferred name:

Child's date of birth: DD / MM / YY Gender: ☐ Male ☐ Female ☐ Intersex

Child's Contact address:

Suburb: Postcode:

Child's indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander ☐ Not stated / unknown
☐ Aboriginal AND Torres Strait Islander ☐ NOT Aboriginal or Torres Strait Islander

2. Parent, Legal Guardian or Approved Foster/ Kinship Carer Details

Family name: Given name:

Preferred Name:

Mobile: Home Phone:

Contact address:

Suburb: Postcode:

Language spoken: ☐ English ☐ Other (specify): Interpreter required? ☐ Yes ☐ No

3. Pre-Screening Questions (please answer all of the following questions)

Was your child born prematurely (less than 37 weeks gestational age)? ☐ Yes ☐ No

Has anyone in your immediate family been prescribed patching or glasses as a child? ☐ Yes ☐ No

Do you have concerns about your child's eyes? ☐ Yes ☐ No

If **yes**, provide details: _____

Does your child wear glasses? ☐ Yes ☐ No

If **yes**, are the glasses for: ☐ Reading ☐ Distance ☐ Both

Has your child seen an eye health professional in the past 12 months? ☐ Yes ☐ No

4. Consent for Vision Screening

The Children's Health Queensland Hospital and Health Service (CHQ HHS) is bound by the *Information Privacy Act 2009*. The CHQ HHS is collecting your and your child's personal information to indicate your preference for your child to participate in vision screening. The completed form and information, whether you consent or decline to participate, will be stored by the CHQ HHS and disclosure of the information may be required in certain circumstances such as when it is required by law, in connection with the patient's ongoing care and treatment, or where you give prior consent. I acknowledge that the results of my child's screening test will be recorded on a secure database which assists with the follow up of children who require further testing or treatment. Information from the database may be used for research purposes but names will not be used in any reports or published information.

Primary School Nurse Health Readiness Program would like to contact you by email for selected screening communications, including reporting vision screening results. Where necessary, email encryption programs will be utilised for sensitive health information. Included in this pack is an information sheet providing information about the risks and conditions of use.

Email: .....

☐ **I have read and understand the information provided in the Consent for Email Communication Patient/Guardian Information Sheet.**

☐ **I consent to be contacted via email by the Primary School Nurse Health Readiness Program**

☐ **I consent to information regarding my child's vision screening results being provided to relevant personnel at their school and other professionals in my child's health care.**

Yes, I consent to have my child's vision screened **OR**

☐ No, I decline to have my child's vision screened

☐ No, I decline as my child has had a vision check in the past 12 months

Parent/guardian name (print): **Signature:**

Relationship to child: **Date:** / /

DO NOT WRITE IN THIS BINDING MARGIN

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Material No.: 1NY32681
SW776

Queensland Government

Primary School Nurse Health Readiness Program

Vision Screening & Privacy Consent

(Affix patient identification label here)

OFFICE USE ONLY

School:

Class:

Child Name:

NURSE TO COMPLETE

Results obtained:

Visual Acuity	Right Eye	Left Eye	Pass / Refer	Sign
Without glasses				
With glasses				

Photoscreen	Pass / Refer	Sign	Date and Time
Without glasses			
With glasses			

☐ Rescreen completed

Visual Acuity	Right Eye	Left Eye	Pass / Refer	Sign
Without glasses				
With glasses				

Date and Time

Comments / observations: _____

☐ Pass

☐ Not passed – **Routine** referral (as per screening protocol)

☐ Not passed – **Intermediate** referral (as per screening protocol)

☐ Not passed – **High priority** referral (as per screening protocol)

Unable to test due to: ☐ Absence ☐ Unable to complete screen ☐ Declined consent

			Sign
Screening result issued to parent/guardian?	☐ Yes ☐ No	Date:____/____/____	
Parent/guardian telephoned?	☐ Yes ☐ No	Date:____/____/____ ☐ N/A	
Updated clinical information?	☐ Yes ☐ No	Date:____/____/____ ☐ N/A	

Intermediate priority referral (parent to choose): ☐ Optometrist ☐ Private Ophthalmologist

High priority referral (parent to choose): ☐ Optometrist (high priority referral) ☐ Private Ophthalmologist

Referral and photoscreen results issued to parent/guardian?

☐ Yes ▸ Date:____/____/____

☐ No ▸ Comment:____ Date:____/____/____

Date	Comments

Nurse name:	**Signature:**
Designation: **Date:**	
Nurse name:	**Signature:**
Designation: **Date:**	

DO NOT WRITE IN THIS BINDING MARGIN ▸