Consent for Screening Vision/Hearing

Student Name: ______________________ Health Care Number: ______________________

Date of Birth: DD/MONTH/YYY ______________________ Parent/Legal Guardian: ______________________

Address and Phone Number: ______________________

School Name, Teacher Name, and Grade Number: ______________________

To be completed by the School Staff: ☐ Visual Acuity ☐ Hearing Acuity (Select one or both to be screened)

To be answered by the Parent/Legal Guardian:

Vision	**Hearing**
1. Does your child have eyeglasses/contacts or a prescription for these?	1. Does your child have a hearing device or a prescription for this?
☐ Yes –see your vision care professional for regular follow up, the nurse will **not** screen.	☐ Yes –see your hearing care professional for regular follow up, the nurse will **not** screen.
☐ No – please complete question two below.	☐ No – please complete question two below.
2. Has your child's vision been assessed by a nurse/doctor/other healthcare provider during this school year or last school year?	2. Has your child's hearing been assessed by a nurse/doctor/other healthcare provider during this school year or last school year?
☐ Yes – If so, see your vision care professional for regular follow-up, the nurse will **not** screen.	☐ Yes – If so, see your hearing care professional for regular follow up, the nurse will **not** screen.
☐ No – please complete the next section.	☐ No – please complete the next section.

Consent to be completed by Parent/Legal Guardian and returned to the school staff:

I give my permission, on behalf of my child ______________________, to the nurse assigned to the school (or designate) for the following screen(s): ☐ Visual Acuity ☐ Hearing Acuity

Parents/Legal Guardians will receive notification of the results of this screen. The results of this screen will be shared with your child's teacher and other appropriate school personnel. Consent is valid for the duration of this school year.

Parent/Legal Guardian's Signature: ______________________ **Date:** DD/MONTH/YYY ______________________

To be completed by the nurse (or designate) and returned to the Teacher after the screen:

Visual Acuity Screen:

☐ No Referral
☐ Rescreen Needed
☐ Referral (notification sent home with student)

Hearing Acuity Screen:

☐ No Referral
☐ Rescreen Needed
☐ Referral (notification sent home with student)

Comments: ______________________

Nurse's Name: ______________________ **Date:** ______________________

Nurse's Signature: ______________________

Eastern Health acknowledges and respects the privacy of individuals. The personal information is being collected under the authority of Sections 29, 30 and 31 of the *Personal Health Information Act* and will be used for processing your Screening Information. If you have any questions about the collection of this information, please contact: Eastern Health, Access and Privacy Office, Southcott Hall, 777-8025.