Consent form for Vision Screening

Please complete and return to your child's school within one week.

Child's Full Name:	Date of Birth:	Boy □ Girl □
Child's Previous Surname *(if any)*:	NHS Number:	Current School:
Name and Address of Previous School including Nursery:		
Your Name:	Relationship to Child *(e.g. parent, relative, guardian, person with parental responsibility)*	Mobile Number:
Address:	Post Code:	Telephone Number:

Consent		
Name and relationship to child:	I confirm I have parental responsibility:	Yes □ No □
I / We consent to my child being seen by the School Nurse Team for vision screening in school and the appropriate information being shared with other professionals, following discussions with me.		
Signature of Parent / Guardian:		Date:

Consent for vision test 21/1/14