Brien Holden
FOUNDATION

Brien Holden Vision Institute Foundation
Level 4 North Wing, Rupert Myers Building,
Gate 14, Barker St, University of New South Wales,
Sydney NSW 2052
www.brienholdenfoundation.org | info@brienholdenfoundation.org
ABN 86 081 872 586

Consent Form for Eye Care

To: Parents/Guardians of Eligible Children Needing Eye Exams

Re: Parental Consent for Brien Holden Foundation Eye Examination and any follow up care

Student Name:__________________________**DOB:** / / **School:**____________________

Parent/guardian name:_________________________contact number:____________________

All eye examinations are **free of charge and bulk billed by Medicare** can you please provide your

Medicare Number________________________________**child reference number:**__________

If your child requires glasses they can be received **free of charge through the NSW Government funded Spectacle Scheme**, if you receive a **centre link benefit.** If you receive a centre link benefit please specify what type of centre link card/benefit you have____

As part of our eye exams we ask some background questions regarding the child's eye and health history. Please fill this form in to the best of your knowledge to help us fully understand your child's eyes and vision.

Child's current eye problems:

Do you have a **main concern** regarding your child's eyes or vision?

☐ No, I'd just like them to have a routine eye examination

☐ ☐ Yes, please describe your main concern:

____

Please indicate to what extent the following apply to your child:

Your **child complains** of the following:

Difficulty seeing far away (e.g. board at school/TV)	☐ Not at all	☐ Sometimes	☐ Almost always
Difficulty focussing up close (e.g. reading/writing)	☐ Not at all	☐ Sometimes	☐ Almost always
Headaches	☐ Not at all	☐ Sometimes	☐ Almost always

You have **noticed behaviours** in your child such as:

Sitting very close to the TV	☐ Not at all	☐ Sometimes	☐ Almost always
Holding a book/electronic device very close to face	☐ Not at all	☐ Sometimes	☐ Almost always
Excessive eye rubbing	☐ Not at all	☐ Sometimes	☐ Almost always

Please provide as much detail as possible about the above complaints:

____

____

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Child's eye & health history:

When was your child's last eye examination? ______________________

Have they ever needed glasses? ☐ No ☐ Yes – are they regularly worn? ____________

Please indicate if any of the following options are relevant to your child/child's family history:

Amblyopia (Lazy Eye) ☐ No ☐ Yes, please specify: ____________

Strabismus (Eye Turn) ☐ No ☐ Yes, please specify: ____________

Myopia/Short Sightedness ☐ No ☐ Yes, please specify: ____________

Blindness ☐ No ☐ Yes, please specify: ____________

Other: ______________________

Medications (prescription, over the counter, herbal etc.) ☐ No ☐ Yes, please list:

____

____

Does your child have any known **allergies**? ☐ No ☐ Yes, please list: ____________

Parent/Guardian Permission for eye examination:

I, ____________ Parent/guardian of, ____________ give my permission for this child to receive a free eye exam and glasses, if needed, by the Brien Holden Vision Institute Foundation when visiting for comprehensive school eye examinations. This consent form is valid from ____________ to ____________.

Parent/Guardian signature ____________ **Date** ____________

Waiver of Dilated Fundus/Cycloplegic Exam- *rarely required, see below for details*

I give my permission for the optometrist to perform a dilated fundus/cycloplegic exam during the examination process at the Brien Holden Foundation eye clinic if required. **It is important that we have a contact number to contact you on the day if we need to dilate your child's eyes.**

Parent/Guardian signature ____________ **Date** ____________

CONTACT TELEPHONE NUMBER: ____________

Dilating eyedrops – what you need to know: The vast majority of children's eye exams do not require dilating eyedrops.

However, if a concern is noted such as a 'lazy eye' (amblyopia), or a turned eye, it is possible that we will need to instil eyedrops into your child's eyes to help determine the exact glasses prescription required. It is an important assessment to ensure the best outcome for your child.

These drops temporarily enlarge the child's pupils and reduce their ability to focus up close. As a result, the child will notice blurred near vision and increased sensitivity to light for several hours, and will recover from these effects completely well within 24 hours.

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EYE EXAMINATION RESULTS: REPORT TO SCHOOL & PARENT/GUARDIAN

Name of child:______________________**DOB:**__________**Date Seen:** ________________

Diagnosis: ☐ Long-sighted (hyperopia) ☐ short-sighted (myopia) ☐ Astigmatism

☐ Other: ____

☐ No Treatment Indicated

☐ Glasses Prescribed

- ☐ To be worn at all times
- ☐ To be worn for far vision activities, e.g. looking at the board
- ☐ To be worn for near vision activities, e.g. computer work, reading, writing
- ☐ Other: ____

Recommended Date for follow-up: ____

Date:___________________________ ___________________________
Name of Examiner

Contact:_________________________ ___________________________
Signature