



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:



Brien Holden FOUNDATION

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

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.



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

