



**Brien Holden  
FOUNDATION**

Brien Holden Vision Institute Foundation  
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## 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:** \_\_\_\_\_ **DOB:**    /    /    **contact number:** \_\_\_\_\_

**[note: we need parent/guardian date of birth to be able to apply for glasses through NSW Government]**

Does your child identify as ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Does your child attend your local Aboriginal Medical Service if Yes, are you happy for us to share their eye examination results with them? ☐ Yes ☐ No If YES what AMS do they attend: \_\_\_\_\_

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 Centrelink benefit. PLEASE supply copy of pension card.**

**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:

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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** \_\_\_\_\_

**CONTACT TELEPHONE NUMBER:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***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 instill 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.