



East Lancashire Hospitals
NHS Trust

Lancashire Vision Screening Service

The Orthoptic Department
St Peters Centre
Church Street
Burnley
BB11 2DL

Tel: 01282 805568

Email: lancashirescreening.elht@nhs.net

Web: www.elht.nhs.uk

Please Note:

**Full PPE and social distancing
will be maintained by our staff
while visiting your child's
school**

Dear Parent/Guardian/Carer,

Vision screening is an integral part of the universal delivery of the national Healthy Child Programme, and meets the criteria laid down by the National Screening Committee, which recommends that all children should be screened for visual impairment between four and five years of age.

Visual acuity continually develops from birth up to the age of seven. This is why it is important to test, detect early and begin any treatment of defects that may occur. The test also reduces the risk of defects developing into visual impairments if left untreated.

Your child's class has been invited to take part in this programme at school. The test will be carried out by staff from the Lancashire Vision Screening Service during normal school hours. This is a non-invasive test that should take no longer than a few minutes. To be able to screen the vision screeners will need to access the name and contact details of your child from the school. This will enable us to send a letter to you, usually within two weeks of the initial visit, to inform you of your child's results. Please be aware that this information will be only be used by the vision screening service and will not be shared.

This is an OPT-OUT system. All children will have vision screening in school unless a reply slip is returned. Please complete the reply slip below if you DO NOT want your child to have vision screening and state the reason for this.

Name of child: _____ Date of birth: _____

Address: _____

Post Code _____

• **I DO NOT** want my child to have vision screening

Please state the reason and tick the appropriate box:

• Already attends orthoptist / Hospital

• Already attends own optician

• Other Please state the reason _____

Signed _____ Name in full _____
(Parent/Guardian/Carer) (Print clearly)