** Special School Eye Care Service**

**ABOUT MY CHILD’S EYES**

|  |  |
| --- | --- |
| **Child’s Full Name** |  |
| **School Name** |  | **Today’s Date** |  |

**Introduction**

This form will provide valuable information to the NHS England Special School Eye Care Team to ensure they can:

* make the eye test and dispensing of glasses (if required) a positive experience for your child
* understand what is already known about the eye health and vision of your child
* receive other information about your child that will help them provide the best possible service.

We will be asking questions in the following categories:

* Your Child’s Details / Your Details
* The Eye Test (Part 1)
* Eyecare History: Visits to the Optician / Visits to the Hospital
* Glasses
* Other Eye Information about your Child
* Other Health Information about your Child
* Eye Information about your Family
* The Eye Test (Part 2)
* 5 Key Questions

Completing the form

Not everything in this form will be relevant to your child but the more information you provide, the more we can tailor the service to your child’s specific needs.

Where answer options are provided, please click on 🞏 to indicate your choice. You can click again to change your choice.

If you are completing the form electronically, the ‘free text’ boxes will expand to as much text as you type.

If you are completing the form by hand, please enlarge the text boxes to the size you require for your information before printing.

Returning the form

When completed, please return this to the school using the details on the Service Participation and Opt-Out form.



*With much gratitude to* ***SeeAbility*** *for the content of this form*

**Your Child’s Details**

|  |  |
| --- | --- |
| **Address & Postcode** |  |
| **Phone Number** |  |
| **Date of Birth** |  |
| **Ethnicity \*** |  |
| **Name of Child’s GP** |  |
| **GP Practice Address** |  |

**\*** Please see last page for options

**Your Details**

|  |  |
| --- | --- |
| **Full Name** |  |
| **Address & Postcode** |  |
| **Phone Number** |  |
| **Email Address** |  |
| **Relationship to Child** |  |

**The Eye Test (Part 1)**

*See also Part 2*

If any of the following are applicable, it would be useful for the Optometrist and Dispensing Optician to see these at the eye test:

* your child’s glasses
* the prescription from your child’s last eye test
* your child’s Education, Care and Health Plan or personal records

|  |  |
| --- | --- |
| **Would you like to attend your child’s first Eye Test at the school?** | [ ]  Yes [ ]  No [ ]  Don’t know  |
| If **Yes** – please bring with you the three items mentioned above if availableIf **No** – please arrange for the school to have these prior to the appointment if available |
| **I am happy for the Optometrist to put drops in my child’s eyes.**[ ]  Yes [ ]  No [ ]  I would like to speak to the Optometrist first*These drops, also known as Cyclopentolate, help the Optometrist to see into the eye through the pupil. They may sting a little and vision may be blurry for a short time. Side effects are extremely rare.* | Eye dropper |

**Eyecare History: Visits to the Optician**

|  |  |
| --- | --- |
| **Has your child ever had an eye test at the Optician/Optometrist?** | [ ]  Yes [ ]  No [ ]  Don’t know*If No/Don’t Know, go to next section* |
| **If yes, Name and address of current Optician/Optometrist?** |  |
| **Date of last check** |  |
| **Date of next check** |  |
| **Can the Eye Care Team contact the Optometrist to access your child’s eye history?***Access to previous records can help the Eye Care Team provide a better service for your child* | [ ]  Yes [ ]  No  |

**Eyecare History: Visits to the Hospital**

|  |  |
| --- | --- |
| **Has your child ever been to the Eye Clinic in a Hospital?** | [ ]  Yes [ ]  No [ ]  Don’t know*If No/Don’t Know, go to next section* |
| **If yes, what was the problem?** |  |
| **Name of the Hospital visited** |  |
| **Date of last appointment** |  |
| **Date of next appointment** |  |
| **Did your child have an operation on their eyes?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Can the Eye Care Team contact the Hospital to access your child’s eye history?***Access to previous records can help the Eye Care Team provide a better service for your child* | [ ]  Yes [ ]  No [ ]  Don’t know |

**Glasses**

|  |  |
| --- | --- |
| **GlassesHas your child been prescribed glasses either by an Optician or from the Eye Clinic at a hospital?**  | [ ]  Yes [ ]  No [ ]  Don’t know*If No/Don’t Know, go to next section* |
| **Has your child been given a patch for their glasses?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Is your child using their glasses now?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Does your child have any problems with their glasses?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **If yes, please describe** |  |

**Other Eye Information about your Child**

|  |  |
| --- | --- |
| **BlindIs your child registered blind / severely sight impaired?**  | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Is your child registered partially blind / severely sight impaired?**  | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Do your child’s eyes always appear straight?** | [ ]  Yes [ ]  No [ ]  Sometimes[ ]  Don’t know |
| **If one or both eyes appear to wander, which eye does this?** **How often does this happen?** | [ ]  Right eye [ ]  Left eye[ ]  Both eyes [ ]  Not applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Do your child’s eyes appear to move excessively rapidly or uncontrollably?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Do you think your child has trouble controlling their eye movements?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **If yes, please give details:** |  |
| **Does your child tend to shut one eye?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **SunDoes your child appear very sensitive to bright lights?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Does your child complain of headaches?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Do you generally have concerns about your child’s eyes?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **If yes, please describe:** |  |

**Other Health Information about Your Child**

|  |  |
| --- | --- |
| **Person in wheelchairDoes your child use a wheelchair?**  | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Does your child have any health problems or disabilities?**  | [ ]  Yes [ ]  No [ ]  Don’t know |
| **If yes, please describe them:** |  |
| **Does your child take any medication?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **MedicineIf yes, please list them: (please take information about the medication to the eye test)** |  |
| **Does your child have any allergies?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **If yes, please list them:** |  |
| **Please give details of any difficulties during the pregnancy or child’s birth:***(eg. mother had infection, prematurity, low birth weight, need for special care, etc)* |  |

**Eye Information about your Family**

|  |  |
| --- | --- |
| **Has anyone in your family had eye problems?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| ***For example, did anyone wear glasses as a child, had a squint (strabismus), a patch over an eye, or an eye condition*?** |
| **If yes, please describe which family member in relation to yourself had the problem and what the problem was?** |
| WHO | WHAT PROBLEM |
|  |  |

**The Eye Test (Part 2)**

When your child has their eye test, the Optometrist will need to:

* look at their eyes
* do some tests to check how well they can see

The information you give below will help the Optometrist to test your child’s eyes and communicate with them effectively.

|  |  |
| --- | --- |
| **Will your child be alright if the Optometrist comes close to them and shines a bright light in their eyes?***This is done with an instrument called a Retinoscope.*[ ]  Yes [ ]  No [ ]  Don’t know? |  |
| **Will your child be alright if the Optometrist was to cover their eyes one at a time?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **Can your child understand better or worse?**[ ]  Yes [ ]  No [ ]  Don’t know?  |  **Better Worse** |
| **Will your child be able to wear test frames on their face?**[ ]  Yes [ ]  No [ ]  Don’t know |  |
| **Can your child say or sign the names of letters on any Eye Test Chart?** [ ]  Yes [ ]  No [ ]  Don’t know |  |
| **Can your child say or sign the names of pictures on a chart (like *house, fish, car)*?** [ ]  Yes [ ]  No [ ]  Don’t know | A picture containing shape  Description automatically generated |
| **Can your child point to a letter or picture on a card that is the same letter or picture on a chart on the wall?** [ ]  Yes [ ]  No [ ]  Don’t know |  |
| **Is your child deaf or hard of hearing?** | [ ]  Yes [ ]  No [ ]  Don’t know |
| **If yes, please give more detail** |  |
| **Does your child find it hard to communicate?** | [ ]  Yes [ ]  No [ ]  Sometimes |
| **Please indicate if your child uses any of the methods below to communicate and describe any other ways you might communicate with your child if appropriate?** |
| Makaton [ ]  Yes [ ]  NoAn interpreter [ ]  Yes [ ]  NoPictures [ ]  Yes [ ]  NoGestures [ ]  Yes [ ]  No | Other ways: |

**5 Key Questions**

These questions may not be applicable to your child but are used to help us identify if they might have problems with their vision that are due to their brain rather than their eyes (known as CVI – cerebral visual impairment).

|  |
| --- |
| **1** **Does your child have difficulty walking down stairs?**[ ]  [ ]  [ ]  [ ]  [ ]  [ ] Never Rarely Sometimes Often Always Not applicable |
| **2** **Does your child have difficulty seeing fast-moving objects?**[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  Never Rarely Sometimes Often Always Not applicable |
| **3** **Does your child have difficulty seeing something that is pointed out in the distance?**[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  Never Rarely Sometimes Often Always Not applicable |
| **4** **Does your child have difficulty locating an item of clothing in a pile of clothes?**[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  Never Rarely Sometimes Often Always Not applicable |
| **5** **Does your child find copying words or pictures time-consuming and difficult?**[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  Never Rarely Sometimes Often Always Not applicable |

|  |  |
| --- | --- |
| **Finally, is there any other information about your child the Optometrist may need to know?** |  |

**Thank you very much for detailing as much information as possible.**

**This will help the visiting Eye Care Team to provide the**

**best eye care possible for your child.**

**Ethnicity options**

This information allow the NHS to measure and improve access, experiences and health outcomes for all patients from all communities. Please choose one to fill in the ethnicity box.

**White**

English, Welsh, Scottish, Northern Irish or British

Irish

Gypsy or Irish Traveller

Any other White background

**Mixed or Multiple ethnic groups**

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed or Multiple ethnic background

**Black, African, Caribbean or Black British**

African

Caribbean

Any other Black, African or Caribbean background

**Asian or Asian British**

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background

**Other ethnic group**

Arab

Any other ethnic group

Sourced from Gov.UK 2021