

Orthoptic Vision Screening for 4-5 year olds

**Who will my Child see?**

Your child will be seen by an eye professional who is trained and experienced at testing a child`s vision.

**What will the Examiner test for?**

They will check the visual acuity (eyesight) of either eye, with the main aim is to pick up reduced vision caused by a need for glasses. This may be in one eye, or both.

**Why are children tested at this age?**

At the age of 4 to 5 vision can be accurately tested using a subjective assessment, in an enjoyable format for children.

It is important that any vision problems are detected early so treatment can be undertaken and not interfere with their education. Treatment of most vision problems caused by a need for glasses (long sight, short sight or astigmatism), detected at this age will achieve a good result.

**What happens at the screening appointment?**

The test will take 5-10 minutes and we aim to make it fun for the child. Your child will be asked to name simple pictures; they do not know the alphabet.

To test the vision in each eye separately, we use a piece of soft paper tape as a patch. This is slightly sticky but does not hurt and most children of 4-5 are quite happy to have one eye covered.

**When will the test be performed?**

The test will be done during the school day. Your child will be taken out of class at a convenient time and returned after the test.

A notification that the test has been performed and the result of the test will come home via school.

**What happens if a problem if found?**

We will write to your GP informing them that a problem has been detected and we have made a referral for further testing, and you will receive a copy of this letter.

The examiner will refer your child for further assessment with an Orthoptist at a local clinic, or at the West of England Eye Unit.

**What if my child is not at school on the day of the test?**

They will be sent a date for an appointment at your local hospital or clinic for the test to be carried out.

**What if I have concerns about my child`s eyes?**

Only visual acuity problems will be detected at our screening appointment. Should you have any other concerns about your child’s eyes, such as noticing a strabismus (eye that turns), a change in the pupil or iris (coloured part of the eye), or any other eye problems you need to take your child to the GP or a local Optometrist. This may lead to a referral to the hospital eye unit or your local clinic.

**What if my child has already had an eye test?**

We recommend they have the vision screening test at school.

**Will my child be offered routine eye tests after this?**

No, this is the only ***routine*** eye test that is offered.

We do recommend that your child visits their own optician every two years to continue monitoring their visual development especially if there is a family history of glasses. They are entitled to free eye tests with an optometrist until they reach the age of 18, or 19 if still in full time education.

**What information do we collect, how we store this information, how long we retain it and with whom and for which legal purpose we may share it.**

Visit our privacy notice at [www.rdehospital.nhs.uk/documents/trust/information-governance/patient-privacy-notice.pdf](http://www.rdehospital.nhs.uk/documents/trust/information-governance/patient-privacy-notice.pdf)

School Vision Screening.

West of England Eye Unit.

Royal Devon & Exeter Hospital.

(01392) 406031

**Please only return this slip to school if you do NOT want your child to have an eye test at school**

I **do not** wish my child to have a Vision Test at school.

Childs Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child`s Class: \_\_\_\_\_\_\_\_\_

Reason (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(We value your reason for not wanting a vision test as this will assist us with future decisions for testing)

Parent / Guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please return this to your child’s school)