

Vision Hearing Team
57 Hanover Street
DUNEDIN
Ph (03) 474 1700
Fax (03) 474 0221

Public Health South

Dear Parent/Caregiver

The Vision Hearing Service offers your child the opportunity to take part in a national screening programme for Distance Vision, Audiometry (Hearing) and Tympanometry (a test to detect "Glue Ear").

If you would like your child to take part in this programme, and be seen by the Vision Hearing Technicians, please complete this form and leave it at your Early Childhood Centre / School for us to collect on our next visit.

AGES FOR SCREENING

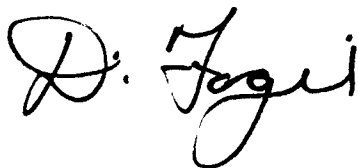
Early Childhood Centre:	3 years Tympanometry (Glue Ear) 4 years Tympanometry and Distance Vision
Primary School:	5 years Tympanometry, Audiometry (Hearing) and Distance Vision.
Year Seven:	Distance Vision (all children) Colour Vision (boys only)

The Vision Hearing Technician will send a letter home with your child following the test. A record of your child's results will then be kept as your child progresses through school and will go with your child's record as they move to other schools.

We will notify you of any problems and you will be advised if a referral is required for further assessment.

If you have any concerns you would like to discuss, please contact us on:
Phone (03) 474 1700 and ask for the Vision Hearing Technicians.

Yours sincerely



VISION HEARING TEAM

Denise Forgie
Eleanor Chisholm
Zandra Davis
Letitia Bootten
Megan Sinclair

PRIMARY HEALTH CARE MANAGER

Sharyn Robson

VISION HEARING CONSENT FORM

Early Childhood Centre/School: _____

Child's Surname: _____

Child's First Name: _____

Date of Birth: _____ Sex: M / F

Ethnic Group: (Please tick group you **most** identify with)

NZ European:

NZ Maori:

Pacific Island:

Asian:

Other: _____

Address: _____

Contact Telephone Number: _____ General Practitioner: _____

Please circle what applies to your child:

Been under care of Ear, Nose and Throat Service: Yes/No Public/Private: Year _____

• Currently has Tubes/Grommets: Yes/No

Been under care of the Eye Service: Yes/No Year: _____

• Are they still under care: Yes/No Reason: _____

• Does your child wear glasses: Yes/No

Is there anything you would like us to know about regarding your child's ears or eyes? _____

Consent (Please read then sign the bottom of this form)

- If you do not wish your child to be included in the Vision Hearing Screening Program please sign and state the reason for this _____

I (do / do not) consent to my child taking part in the Vision Hearing Screening Programme, and the above information being kept in my child's vision hearing record. I understand that following discussion with me, the GP, Eye/ENT Service and myself will receive a referral letter regarding the outcome of these tests.

PARENT/CAREGIVER (Giving Consent)

Name: _____ Relationship: _____

Signed: _____ Date: _____