

NAME

DOB: XXXX

School: XXXX

Please tick (✓) the box that applies.

Your child:

- **Passed the school vision screening test with the School Nurse**

(met the standard of vision, no further review by the school nurse)

- **Did not pass the school vision screening test with the School Nurse**

(required further vision testing with an optometrist/optician or orthoptist, a referral form would have been included in your letter from the School Nurse)

- **Did not take part in school vision screening with the School Nurse**

- **Was not offered school vision screening with the School Nurse**

OR

- **I am unsure of the result of my child's vision screening test with the School Nurse**