CONSENT FORM

The Department of Education (the department), which includes all Victorian government schools, and central and regional offices, is providing funding to State Schools' Relief (SSR) which is a charitable non-government organisation, to manage and deliver the Glasses for Kids program (the Program) at 297 targeted schools between 2024 and 2027.

Your consent is needed for your child to participate in the program.

4 simple steps to be part of the Glasses for Kids program...

1. **Read the Information for Families Brochure**
2. **Complete the Consent Form and Optometrist Questionnaire**
3. **Give both forms back to school**
4. **Ensure that your child is at school on the day of visit**

Privacy and Information Handling

The personal and health information collected through this process will be held by your child's school, State Schools' Relief and the relevant program partners (optometrists) who conduct and supervise the screening and testing of your child.

The information collected is used for the purpose of administering and providing the services of the Program. This Consent Form and Optometrist Questionnaire will be shared with the appropriate school staff, staff within SSR and the program partners optometrists, who require such information to facilitate your child receiving services provided through the Program, or otherwise when permitted or required by law. If required, you can request access to the information collected about your child for the Program by contacting your child's school in the first instance.

The department, SSR and its relevant program partners will handle your and your child's personal and health information (including on this form and the eye health questionnaire) in accordance with the Privacy and Data Protection Act 2014, the Health Records Act 2001, the department's privacy policies.

The department's privacy policies can be found here: https://www.education.vic.gov.au/Pages/privacy.aspx

Please complete all details if you consent to your child participating in the Glasses for Kids program

I confirm that I have read the Information for Families brochure.

I understand that an optometrist may need to clarify or discuss further details with me on the day of my child's visit, and have provided my phone number.

I understand that if glasses are required, my child will select these on the day from SSR's range of frames. These will be delivered to the school after the visit.

I authorise and consent to my child receiving free initial vision screening and if needed, testing and glasses by a registered optometrist at school through the Program.

CONSENT FORM

I give permission and consent for my child

Student First Name *(as per Passport or Medicare)*:

Student Surname *(as per Passport or Medicare)*:

Date of Birth *(DD/MM/YYYY)*: **to participate in the Glasses for Kids program.**

School:

Year level: **Class:**

Parent/Carer Name: **Phone:**

Parent/Carer Signature: **Date** *(DD/MM/YYYY)*:

Medicare Details

If you do not have a Medicare card, you may still participate in the Glasses for Kids program.

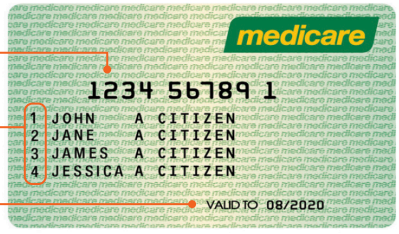
- All participating students will receive free initial vision screening.
- GFK program partners require your Medicare number if your child requires Comprehensive Eye Testing.
- Comprehensive Eye Testing may be bulk billed through Medicare.

If the student does not have a Medicare card, please leave this section blank.

Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐

Individual reference number ☐

Expiry date ☐☐/☐☐☐☐



PLEASE TURN OVER

OPTOMETRIST QUESTIONNAIRE

Child's Details and Eye Health

When was your child's last eye exam with an optometrist? ☐ Never ☐ 1 year ☐ 2 years ☐ 3 years ☐ 4+ years

Does your child wear glasses? ☐ Yes ☐ No

If your child currently wears glasses, please attach their most current prescription if available.

Has your child ever had eye surgery? If yes, please describe:

Has your child ever had vision therapy, such as eye exercises or patching? If yes, please describe:

Family Eye Health

Does anyone in the family have any of the following?

☐ Amblyopia (lazy eye) ☐ Hyperopia (far sighted) ☐ Astigmatism (blurred vision) ☐ Other .....

☐ Strabismus (cross eye/s) ☐ Myopia (near-sighted) ☐ Nystagmus (rapid eye movement) ☐ None/Unsure

Observations

Please tick any of the following that you or your child's teacher has observed:

☐ Blurred distance vision ☐ Near blur/double vision ☐ Squints or blinks excessively ☐ Headaches

☐ Tilts head ☐ Avoids close work ☐ Closes one eye/squints when reading ☐ Red or watery eyes

☐ Eye turns in/out/up ☐ Uses finger to read ☐ Takes out small words when reading ☐ Holds books too close

☐ Loses place when reading ☐ Skips or re-reads lines ☐ Reverses letters and numbers ☐ Words move or run together

☐ Slow reading ☐ Poor spelling ☐ Other .....