



Gorey Primary Care Centre,
Block B, The Palms Centre,
The Avenue,
Gorey, Co. Wexford.
Phone: 053/9481600

School Health Screening Vision & Hearing Consent School Year **2026/2027**

Dear Parent/Guardian,

A School Health Screening Service to identify children who may have problems with their vision (eyes) and/or hearing will be carried out by the Public Health Nurse (PHN) in your school. If any problems are identified they will be referred to a specialist service for further testing.

Consent: Please complete both sides of this consent form . Additional information recorded on the reverse side of this form will be helpful when completing the screening test

- **Indicate clearly your consent yes/no option.**
- **Return the form to the class teacher in a sealed envelope marked for the attention of school screening staff – whether you choose to give your consent or not.**
- **or post directly to the above address.**

Screening Tests: The vision screening involves reading or matching letters from a chart. The hearing screening will involve listening to sounds through headphones. If your child needs to be referred for more tests we will contact you. If a repeat hearing screening is necessary, this will be done 6-8 weeks later depending on the results of the first screening. The second screening (if required) will also be carried out in the school or HSE clinic.

Other Services. The School PHN is available to discuss or complete onward referrals for:

- Speech and Language Therapy
- Growth
- Toilet Training - Enuresis
- Other (give details overleaf and the School PHN will contact you)

Regards

B. Redmond / S. Sharif
School Screening Secretary

Consent Form

Childs Name: _____

D.O.B. ___/___/___

YES:

No

I WANT MY CHILD TO HAVE

I DO NOT WANT MY CHILD TO HAVE

VISION SCREENING

VISION SCREENING

HEARING SCREENING

HEARING SCREENING

Please sign _____

Please sign _____

Parent/Guardian Date: ___/___/___

Parent/Guardian Date: ___/___/___

Personal Details

Child's name _____ Date of Birth ___/___/___ Male Female

Address _____

Mother's Maiden name _____ G.P. _____

Contact number _____ Mobile: _____

Previous Address (if any) _____

School Name _____ Class _____

Previous School (if any) _____

Vision:

Do you have concerns about your child's vision? No: Yes:

Details _____

1. Has your child ever been referred to any eye specialist? No: Yes:

2. If yes please name doctor or clinic _____

HSE Clinic: / Private Clinic:

3. Does your child wear glasses? No: Yes:

Hearing:

1. Do you think your child has hearing problems? No: Yes:

Details: _____

2. Has your child ever been referred to a hearing specialist or E.N.T.? No: Yes:

Details _____

HSE Clinic: / Private Clinic:

3. Does your child wear hearing aids? No: Yes:

4. Has the school's PHN your permission to discuss with the teacher any concerns regarding your child's hearing and vision which may affect his/her progress at school? No: Yes:

"Other Services / Concerns"
