**Learning on TAP**

# Vision and hearing screening for school-age children
Consent form

| | |
|---|---|
| [Service provider logo] | Screening coordinator: |
| | Date of screen: |
| | Location: |

## Why is screening important?

Your child's vision and hearing are important for their learning. The World Health Organization recommends that every child has their vision and hearing screened by trained personnel.

## What will happen during the screening?

During the screening, your child's vision and hearing will be tested. Someone will look closely at your child's eyes and ears to check if they are healthy. No medicine will be given, and it will not be painful for your child.

## What do I need to prepare?

If your child wears spectacles, they will need to bring them on the day of screening.

## What will happen after the screening?

You will be informed of the results and if any action is needed. The results will be shared with the screening coordinator. They will contact you if any action is needed.

## How do I use this form?

Please read the questions carefully and mark inside the box ☐ to answer. You may be asked to give more information. Please write a short answer where you see the pencil ✎.

| **1. Information about the child** | |
|---|---|
| Family name ✎ | Given names ✎ |
| Date of birth ✎ | Gender: Male ☐ Female ☐ Other ☐ |
| Address ✎ | |
| School ✎ | Class ✎ |
| **Parent/caregiver details** | |
| Family name ✎ | Given names ✎ |
| Phone/email ✎ | |
| Languages spoken ✎ | |

| **2. Consent for sensory screening** *Please tick one* |
|---|
| **Yes,** I consent to vision and hearing screening for my child and to the results being shared with the school screening coordinator ☐ → *Please continue to the next section* |
| **No,** I decline vision and hearing screening for my child ☐ → *Please explain why* ✎ |

| **3. Pre-screening questions** *Please answer if "Yes" selected above.* | | |
|---|---|---|
| Does your child wear spectacles? | Yes ☐ → What are the spectacles used for?<br>Seeing things in the distance ☐<br>Seeing things that are near ☐<br>Don't know ☐ | No ☐ |
| Does your child use hearing aids? | Yes ☐ | No ☐ |
| Does your child have diabetes? | Yes ☐ | No ☐ |
| Does your child have any current pain, discomfort and/or severe itchiness in the eye? | Yes ☐ | No ☐ |
| Do you have any concerns about your child's vision? | Yes ☐ → *Please describe* ✎ | No ☐ |
| Do you have any concerns about your child's hearing? | Yes ☐ → *Please describe* ✎ | No ☐ |

| **4. Signature** *Please sign below and return this completed form to* ***[insert coordinator name/school/facility name]*** | |
|---|---|
| Parent/caregiver name ✎ | Relationship to child ✎ |
| Parent/caregiver signature ✎ | Date ✎ |