Glendenning Public School
135 Armitage Drive
GLENDENNING, NSW 2761.
Ph: 02 9832 8555 Fax: 02 9832 8724
Email: glendennin-p.school@det.nsw.edu.au

FREE EYE TESTING FOR KINDERGARTEN STUDENTS

Dear Parent/Guardian,

The school is pleased to announce that it will again be running a welfare initiative called the **Student Eyecare Program**. An optometrist will be onsite during school hours to provide students with a comprehensive eye examination. This will be done by appointment only and typically takes up to 20 minutes. The parent of each attendee will receive an individual report regarding their child's eye health and a prescription will be provided if glasses are required. The school will not have access to the individual report but will be notified if glasses were recommended. Please note that this service does not sell glasses and the prescription can be taken to any optical store.

The program's aim is to detect visual problems that may interfere with a student's learning abilities and subsequently hinder their academic potential. A significant number of students have visual problems that go undetected. The main visual issues that go undetected are **inadequate focusing** and **eye teaming abilities** that could lead to symptoms, such as poor concentration, fatigue, headaches and unwillingness to read.

This free eye health service is available to all students and is covered by Medicare Australia. The form on the next page is to be completed by the parent or guardian. Testing will occur at our school between 7th - 18th September, 2020.

If you DO wish for your child to participate in the program, please fill in the medicare details and questionnaire attached and return the form to your child's classroom teacher by Monday 31 August.

If you DO NOT wish for your child to participate in the program, please tick that box on the form and return the form to your child's classroom teacher by Monday 31 August.

Doug Meaney
Principal
20 August 2020

Shevee Summerrell
LAST Coordinator

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Please complete and return to your child's teacher.

Please tick one of the following:

- ❑ I **DO** want my child's eyes examined as part of the **Student Eyecare Program**.
- ❑ I **DO NOT** want my child's eyes examined as part of the **Student Eyecare Program**.

Medicare Details

Name of student as appearing on card: _____ Class: ____

Valid to: ☐☐/☐☐☐☐ Date of Birth: ☐☐/☐☐/☐☐

Medicare number: ☐☐☐☐ ☐☐☐☐☐ ☐

List Number on Left of your child's name: (eg. 1, 2, 3 or 4): ☐

Parent's Signature (to agree to Medicare Bulk Billing): _____

Date: _____

QUESTIONNAIRE Please tick the appropriate box:

My child experiences...	**Never**	**Sometimes**	**Frequently**	**Always**
Headaches when working				
Words running together when reading				
Burning, itchy, watery eyes				
Skipping/repeating lines when reading				
Avoids working/reading				
Skipping words when reading				
Trouble keeping attention when reading				
Poor reading comprehension				
Is below grade level				