**HOSPITAL or PROVIDER NAME/LOGO**

Hospital/provider address

Department of Orthoptics – Vision Screening Service

Contact details: phone number

11 July 2023 [date in full in this format]

Dear Parent/Carer of child’s name

**Vision screening for children aged 4 to 5 years**

We are inviting your child to receive vision screening. This will take place at name of school during the week commencing date [in above format].

We enclose an information leaflet to explain what vision screening is and what happens if your child is found to have reduced vision. Please take time to read this information.

Please complete the reply slip below to tell us whether or not you want your child to have vision screening.

**……………………………………………………………………………………………………………………**

**Vision screening at age 4 to 5 years**

Name of child: …………………………………………………… Date of birth: …………………………

Address: ……………………………………………..………………………………………………………..……

Postcode: ………………………………….

I **DO** want my child to have vision screening (tick box if appropriate)

or

I **DO NOT** want my child to have vision screening (tick box if appropriate)

Signed (parent/carer) …………………………………………………….………….………………………..

Name in full (print clearly in capital letters) …………………….…………………..………………

**Please return this reply slip to your child’s school by date [in above format]**