Dear Parent/Guardian,

The school is pleased to announce that it will be running the Student Eyecare Program this year. An optometrist will be onsite during school hours to provide students with a comprehensive eye examination. This will be done by appointment only. Each attendance will receive an individual report regarding the eye health and a prescription will be provided if glasses are required. Please note that this service does not sell glasses and the prescription can be taken to any optometry 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 eye health service is available to local students and is covered by Medicare Australia. The form below is to be completed by the parent or guardian. Students will then receive their appointment letters in roll call class, which will specify the dates and times of their appointments. The eye examination typically takes up to 20 minutes.

1. If you do not wish for your child to participate in the program, please fill in your child’s name and tick the box below. Please return the form ASAP.

Name: ________________________________ Roll Call Class: ____________

☐ I am not interested in having my child’s eyes examined.

______________________________________________ OR ________________________________

2. If you do wish for your child to participate in the program, please fill in the medicare details below and return the form ASAP.

☐ I am interested in having my child’s eyes examined

Medicare Details
Eyes Examined within Two Years? (please circle) Y / N

Name of student as appearing on card: ________________________________ Roll Call Class: ______

Valid to: _________/_______/_______ Date of Birth: _________/_______/_______
Medicare number: ____________________________
List Number on Left Of your Name: (eg. 1, 2, 3 or 4): □

Parent/s Signature (to agree to Medicare Bulk Billing): __________________________ Date: ______________

FORBES STREET LIVERPOOL NSW 2170  I  PH: 9602 7979  I  FAX: 9821 4068
EMAIL: liverpoolb-h.School@det.nsw.edu.au
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