To Parent/Carer

 VISION SUPPORT TEAM

 *‘Removing barriers to learning’*

##### Request to become involved with your child

We would grateful for written permission to become involved with your child. This will allow us to provide appropriate support. We may:

* + contact the Health Service and Orthoptist to find out about your child’s vision
	+ pass on information to you and to staff in settings or schools
	+ test your child’s vision in the setting if appropriate
	+ let you know about other services which maybe available

Wirral University Teaching Hospital Trust may share relevant patient information with the Visual Support Team following their eye appointments.

###### Please complete the permission slip below and return this letter to the setting or directly to us at the above address.

If you would like to speak to someone about this, please telephone the Vision Support Team on 0151 666 5093.

With thanks,

Vision Support Team

**Name of child: ……………………………………………..date of birth: ……………….**

**Setting/school: ……………………………………………contact number ……………**

**Orthopist/Optomotrist ……………………………………………………………………..**

**Registered sight impaired** Yes/No **Registered** **severely sight impaired** Yes/ No

*I am happy for Vision Support Team to become involved with my child and for details of my child’s eye condition to be released to this Team.*

**Name of parent/carer: ………………………………………………’phone…………**

**Address: ……………………………………………………………………………………**

**GP……………………………………**

**Parent/carer signature: …………………………………………… date: ………….**