

**Vision Impairment Team**

Parent/Carer Questionnaire

**Medical Consent Form**

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| **Name of child:** |  |
| **Date of birth:** |  |
| **School:** |  |
| **Hospital (where vision is checked):*****Including address and contact details*** |  |
| **Name of consultant:** |  |
| **Hospital number (if possible):** |  |
| ***I agree to the specialist teacher from Chadsgrove School Support Services\* having access to my child’s medical records.*** |
| **Name of Parent/Carer:** |  |
| **Signature:** |  |
| **Date:** |  |
| ***To be returned as part of the referral paperwork*** |

\*Specialist teachers (VI) are based at New College Worcester and operate on behalf of the Vision Impairment Team at Chadsgrove School Support Services