



Toronto Foundation for Student Success

## Vision and hearing screening clinics available at your school!

### Sight and Sound Program

Vision and hearing screening services are being offered to children within your school community. These are optional services, offered in school-based clinics operated by the Toronto Foundation for Student Success (TFSS), the independent, registered charitable organization dedicated to supporting Toronto District School Board's children and helping remove barriers to their education. A nominal registration fee is collected to cover administrative costs to support the program.

Vision and hearing checks are conducted by international medical graduates and by a certified communicative disorder assistant. Based on the outcome of these screening services, referral information will be provided to families whose children require further assessment.

If you wish your child to participate in these optional services, please complete this form and return it to the school office with the payment attached. A minimum of 25 students are required to attend in order for a clinic to run. You will be notified of the schedule once the clinic has been confirmed.

Thank you.

#### PLEASE PRINT CLEARLY

Student's First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Birthday DD/MM/YY Grade/Class \_\_\_\_\_ Teacher \_\_\_\_\_

School: \_\_\_\_\_



#### Students in Kindergarten - \$10 for one or both tests.

I would like to have my child's  Vision only  Hearing only  Both checked. Enclosed is \$10.00

#### Students in Grades 1 through 12 - parents can choose one or both services:

I would **only** like to have my child's **vision** checked. Enclosed is \$10.00.

I would **only** like to have my child's **hearing** checked. Enclosed is \$10.00.

I would like to have **both** my child's **vision AND hearing** checked. Enclosed is \$15.00.

Payment may be either by cash or cheque, payable to Toronto Foundation for Student Success.

**Please note:** For children 19 years of age and under, OHIP covers the cost of an eye examination with an optometrist once a year.

Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ DD/MM/YY





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# Sight and Sound Program

**For Office Use Only**

## Vision Clinic Results

Does patient use prescription glasses?  Yes  No

Does patient wear the glasses?  Yes  No

Distance vision test:

Right Eye (cover left eye) \_\_\_\_\_

Left Eye (cover right eye) \_\_\_\_\_

Distance vision test with prescription glasses:

Right Eye (cover left eye) \_\_\_\_\_

Left Eye (cover right eye) \_\_\_\_\_

Near vision test:

Right Eye (cover left eye) \_\_\_\_\_

Left Eye (cover right eye) \_\_\_\_\_

Near vision test with prescription glasses:

Right Eye (cover left eye) \_\_\_\_\_

Left Eye (cover right eye) \_\_\_\_\_

Stereo Fly:  Yes  No

Ishihara Colour Test:

Right Eye \_\_\_\_\_ /7 Left Eye \_\_\_\_\_ /7

Stereo Acuity: \_\_\_\_\_ seconds of arc

Four dot test: Dots seen? \_\_\_\_\_ Colour seen  Yes  No

Vision colour deficiency  Yes  No

**Recommendations:**

Vision is within normal range  Vision is within normal range with glasses  Referral to optometrist  Unable to assess

**Comments:**

Name of Screener \_\_\_\_\_

Date: \_\_\_\_\_ DD/MM/YY

## Hearing Clinic Results

Ambient Noise Check:  Yes  No (biological test at 10 db)

Visual Otoscopy:

Right:  Pass  Refer  Could not test

Left:  Pass  Refer  Could not test

Tympanometry Screen:

Right:  Pass  Refer daPa \_\_\_\_\_ ECV \_\_\_\_\_  Could not test

Left:  Pass  Refer daPa \_\_\_\_\_ ECV \_\_\_\_\_  Could not test

Pure Tone Screen (20db):

	Pass	Refer	1000 Hz	2000 Hz	4000 Hz	Could not test
Right						
Left						

OAE Screen:

Right:  Pass  Refer  Could not test

Left:  Pass  Refer  Could not test

**Recommendations:**

Hearing is within normal range  Referral to physician

**Comments:**

Name of Screener \_\_\_\_\_

Date: \_\_\_\_\_ DD/MM/YY