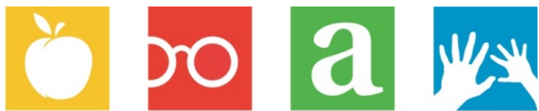


Vision and hearing screening clinics available at your school!

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**.*

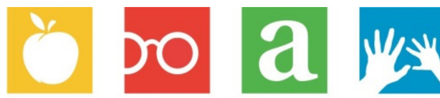
☐ *I would like to have **both** my child's **vision AND hearing** checked. Enclosed is **$15.00**.*

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 ____________



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

Stereo Acuity: ______ seconds of arc

Ishihara Colour Test:
Right Eye ______ /7 Left Eye ______ /7

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

tfss.ca

Toronto District School Board