**PARENT/CARER PERMISSION SLIP**

**PLEASE PROVIDE CHILD’S DETAILS BELOW**

Re: d.o.b. \_\_ \_ \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to a teacher for the visually impaired from Joseph Clarke Service visiting my child at

school/pre-school, obtaining school progress data, obtaining medical information about my child’s eye condition now and being added to the circulation list in the future. *Please note in cases where direct contact with your child is through a video conference call, a parent/carer must be present at all times if at home and a member of the school’s SEN team if at school.*

**PLEASE COMPLETE HOSPITAL AND SPECIALIST DETAILS. WE ARE UNABLE TO VISIT**

**WITHOUT THIS INFORMATION.**

**The Hospital is……………………………………… Hospital No. …………………………….**

**My child's Specialist is……………………………. Date of next appt.………………………**

**Signed………………………………………………… Date……………………………………….**

**How we use and store and share this information**

* The personal information we gather is *only* used by us to help your child at school (if any) and at home.
* It will only be shared with you, the school and directly relevant professionals.
* We use the information gathered to write reports and make suggestions for the school (if any) and you.
* The information is stored on a secure internal database. By default we retain it until your child is 25 years old.
* You may request a copy of all information that we retain at any time and ask for it to be amended or deleted.