Vision and Hearing Screening
Opt Out Request

Please complete and return to your child's school

Student's Name: ______________________________ **Date of Birth:**_____

School of Attendance :_______________________________________

I hereby opt my child out of the following screenings:

(circle all that apply)

Vision Hearing

________________________________ ____________________

Parent Signature **Date**

This form will remain on file until revoked in writing by the parent.

Copies: Cum School Nurse Hx Services