



School Vision Screening Monitoring Waiver

School Year: 20__-20__

Student's Name: _____

I, _____, the parent/legal guardian
of _____, request that he/she be exempt from the state
mandated annual school vision screening/monitoring for the current school year. I understand that **this waiver to exclude my child needs to be renewed each school year** or my child's vision may be
screened/monitored as mandated by the Ohio Department of Health guidelines for school vision
screenings. I understand by choosing to exempt my child from the district vision screening/monitoring, I
cannot hold the district liable in any way for any undetected changes in vision/vision health or for
any related services/accommodations that he/she may not receive due to any unidentified changes
in vision/vision health. I further understand that should I wish to revoke this waiver during the
present school year, it is my responsibility to provide a written and signed note to the school nurse
at least two weeks prior to the school's scheduled vision screening/monitoring.

Signature of Parent/Legal Guardian

Date

Printed Name of Parent/Legal Guardian

This area for office use only:

Received by: _____ Date: _____