RICHLAND ONE

ENGAGE • EDUCATE • EMPOWER

NURSING SERVICES DEPARTMENT

Permission for Vision and Hearing Screening

Student's Name: _____Date of Birth:_____

School:_____ School Year:_____

Based on recommendations from the South Carolina Department of Public Health (SCDOPH) mass screening guidelines, a vision and hearing screening is recommended for your child. The priority screening will be conducted by the school nurse on_____. Parents/guardians may request their child not be screened at school, and this request should be submitted in writing. By signing in the appropriate space below, you give/do not give (circle the correct choice) the school nurse permission to perform and if needed to share a vision and hearing screening assessment on the student listed above.

Please contact the school nurse at the school listed above with any questions or concerns regarding vision and hearing screenings. Sincerely,

_____

School Nurse

I give permission for my child to be screened at school.

_____ _____

Signature of Parent/Guardian **Date**

I <u>DO NOT</u> give permission for my child to be screened at school and will provide documentation of screening results performed outside of the school district.

_____ _____

Signature of Parent/Guardian **Date**