Pickerington Local School District
Vision Screening Waiver

Date: _____

To: Parent(s)/Guardian of _____

School Year: 20____ - ___

Child's Name: _____

School: _____

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: _____