**Dear Parent/Guardian,**

The Rye City School District's School Health Services program supports your child's academic success by promoting health in the school setting. One way we provide care for your child is by performing the health screenings mandated by the State of New York.

During this school year, the following screenings will be required or completed at school if they have not already been documented by your child's doctor on their Health Appraisal form.

**Vision**

- Distance and near acuity for all newly entering students, and students in Pre-K or Kindergarten, Grades 1, 3, 5, 7, and 11.
- Color perception screening for all newly entering students.

**Hearing**

- Hearing screening for all newly entering students, and students in Pre-K or Kindergarten, Grades 1, 3, 5, 7, and 11.

**Scoliosis**

- Scoliosis (spinal curvature) screening for all girls in Grades 5 and 7, and boys in Grade 9.

A letter will be sent home if your child needs to follow up with your health care provider. For vision screenings, parents/guardians will be notified of all results.

**Parental Opt-Out**

If you do **not** want your child to participate in any of the above screenings, you may **opt out** by completing and returning the attached opt-out form to your school's Health Office prior to the scheduled screening date.

Please contact your school's Health Office if you have any questions or concerns. Thank you for supporting your child's health and well-being.

# K–12 Health Screening Opt-Out Form

**Student Information:**

- Student Name: _____
- Grade: _____

**Parent/Guardian Information:**

- Name: _____
- Phone: _____
- Email: _____

**Health Screenings Offered by Grade:**

| Screening | Grades | Notes |
|---|---|---|
| Vision | K–12, new entrants | Distance visual acuity; near vision as needed; color perception for new entrants |
| Hearing | K, 1, 3, 5, 7, 11, New entrants | Pure-tone audiometric screening at 500, 1000, 2000, 3000, 4000 kHz with additional frequencies of 6000 & 8000 kHz for students in grades 7 & 11 |
| Scoliosis | 5th&7th grade girls<br>9th grade boys | Physical exam of the spine for curvature |

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**Opt-Out Declaration:**

I, the undersigned parent/guardian, **do NOT give permission** for my child to participate in the following health screening(s):

☐ Vision
☐ Hearing
☐ Scoliosis

**Reason for opting out (optional):** _____

I understand that these screenings are **required by New York State for all students**, and by opting out, I am choosing to decline them for my child.

**Parent/Guardian Signature:** _____
**Date:** _____