



## School Vision/Hearing Screening Waiver

MVCSD Health Services

Date: \_\_\_\_\_

### Vision/Hearing Screening Waiver

School: \_\_\_\_\_

School Year: \_\_\_\_\_ - \_\_\_\_\_

I \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_, request that he/she be exempt from the state mandated annual school vision and hearing screening 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 and hearing may be screened/monitored as mandated by the Ohio Department of Health guidelines for school vision and hearing screenings.

I understand by choosing to exempt my child from the district vision and hearing screening, I cannot hold the district liable in any way for any undetected changes in vision and hearing health or for any related services/accommodations that he/she may not receive due to any unidentified changes in vision/hearing 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.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Legal Guardian

*This area is for office use only:*

Received by: \_\_\_\_\_ Date: \_\_\_\_\_