Lordstown Local Schools
1776 Salt Springs Rd Warren, Ohio 44481
330.824.2572/ 330.824.2568 Fax

Date: _____

To: Parent(s)/Guardian of _____

School Year: 20_____

Child's Name: _____

School: _____

I, the parent/legal guardian of _____ of _____ (school), request that he/she be excused from the state-required school vision screening for this school year.

I understand that:

This waiver must be renewed every year.

If I do not renew it, my child may be screened as required by the Ohio Department of Health.

By choosing this waiver, I cannot hold the district responsible for any vision problems that are not found.

My child may not receive services or accommodations for any vision problems that are not identified.

If I want to cancel this waiver later, I must give a written, signed note to the school nurse at least two weeks before the school's screening date.

_____
Signature of Parent/Legal Guardian

_____
Date