

Health Screening Permission Slip

I grant permission for my child,

_____, Grade _____

Teacher _____,

Circle one: Male Female, Age _____, DOB _____

to participate in one or more of the health screenings below.

Please check any screening that your child will participate in.

_____ \$8.00 Vision Screening

_____ \$8.00 Hearing Screening

_____ \$8.00 Spinal Screening

Please enclose payment with signed permission slip and return to the school.

Make checks payable to: **DUNN CPR/School Health.**

I understand that these procedures are non-invasive and will be conducted in accordance with the **Texas State Law** regarding Vision, Hearing, Spinal and Acanthosis Nigricans (Pre-Diabetic) Screenings. Additionally, I am to receive a written copy of the screening results and a written referral if one should be needed.

Signed: _____ Date _____

Relationship to the student: _____

Please sign and returned with payment

I do not want my child to participate in the health screening. I understand that I must provide the school with a report of the health screenings, which I may obtain on my own. These results will be in the School Office on or before _____.

(Please include a date)

Signed: _____ Date _____