School Vision and Hearing Screening Waiver

Date:_____

To: Parent/Guardian of:_____

Vision and Hearing Screening Waiver

School Year: _____

Child's Name: _____

School: _____

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 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 or hearing health or for any related services/accommodations that he/she may not receive due to any unidentified changes in vision or hearing. 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 and hearing screening.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Printed Name of Parent/Legal Guardian