



# Health Screening Permission Form



Dear Parents,

During the school year, we will conduct vision, hearing and scoliosis health screenings. The Catholic School Board requires that each child (in the indicated grades) participate in the screenings. If you choose not to have your child tested, we require a signed release from your family physician or pediatrician.

Signing the blanket permission slip below does not mean that your child will be tested for all the screenings: only the screenings indicated by your child's grade.

**In addition, state law requires that each student's height and weight be on file. Please complete the section below for each of your children in school.**

Family Name \_\_\_\_\_

- |          |              |              |
|----------|--------------|--------------|
| 1) _____ | Height _____ | Weight _____ |
| 2) _____ | Height _____ | Weight _____ |
| 3) _____ | Height _____ | Weight _____ |
| 4) _____ | Height _____ | Weight _____ |
| 5) _____ | Height _____ | Weight _____ |

I give permission for my children to receive the following grade appropriate screenings:

Hearing Screening  yes  no

Required in grades K-3

My child has a permanent hearing impairment in the  right  left ear.

My child has tubes in the  right  left ear.

My child(ren) will not participate in the hearing screening. Attached is our signed release from our physician.

Vision Screening  yes  no

Required in grades 3 and 5

My child(ren) will not participate in the vision screening. Attached is our signed release from our physician.

Scoliosis Screening  yes  no

Required in grades 6 and 8

My child(ren) will not participate in the scoliosis screening. Attached is a signed release from our physician.

Family Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Telephone \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_