## VISION AND HEARING CONSENT FORM

School Name: _	St. Paul's Lutheran Sch	pol		
Child's Name:				
	First Name	M.I.	Last Name	
Gender:	M F	Grade:	Date of Birth:	
Parent/Guardiar	n Name:			
Address:			Phone:	
City:		State:	Zip:	

I hereby authorize Valerie Bennett, certified Hearing & Vision Technician, to perform a vision and hearing screening on the child listed above. I also acknowledge that the results from the hearing and vision screenings will be released to the above mentioned school.

I understand that the vision test is required for all preschoolers, 2<sup>nd</sup> graders, 8<sup>th</sup> graders, special education students, teacher referrals, and transfer students, and is recommended for 6<sup>th</sup> graders. The fee for each screening is \$4 and must be paid prior to the date of the screening. In lieu of the screening services required, the school will accept a completed and signed form indicating that an eye examination by a doctor specializing in diseases of the eye or a licensed optometrist has been administered within the previous 12 months.

I understand that hearing tests are required for all preschoolers, kindergarteners, 1<sup>st</sup> graders, 2<sup>nd</sup> graders, 3<sup>rd</sup> graders, special education students, teacher referrals, and transfer students. The fee for the screening is \$4 and must be paid prior to the date of the screening. In lieu of the screening services required, the school will accept a completed and signed form indicating that the child had an ear examination by a physician and an audiological evaluation completed by an audiologist within the previous 12 months.

No tests are required for those students who already wear glasses or have hearing enhancement devices.

Parent/Guardian Signature	Date
<i>Screening Staff Only:</i> Date Screening Completed:	
Vision Screening: PASS FAI	L Referred for Glasses: YES NO
Hearing Screening: PASS FAI	L
Vision / Hearing Screening Completed By:	