Opt In/Out Form for Nursing Services 2017/2018 School Year

Childs Name_____ DOB _____Grade_____

Parent/Guardian Name:_____

Phone:_____

Address_____

Email address_____

Please indicate if you would like to OPT OUT of any of the following Nursing Services offered:

In–school vaccines:

☐ I choose to opt out of this option.

Dental Screening:

☐ I choose to opt out.

Vision Screening: (in order to opt out, the child has to have been evaluated within the last 6 months, please provide the date your child was last seen.)

☐ I choose to opt out. My child last saw the eye doctor on the following date:_____

Hearing Screening: (in order to opt out, the child has to have been evaluated within the last 6 months, please provide the date your child was last seen.)

☐ I choose to opt out. My child was last screened on the following date:_____

Height/Weight/BMI/Blood Pressure:

☐ I choose to opt out of this service.

Menses/Hygiene talk (5th grade students only):

☐ I choose to opt out of this service.

Parent signature:_____ **Date:**_____