School Health Screening Waiver

Date:_____________________________ School Year:____________________

Child's Name:____

School: ____

Screenings

- ☐ Dental/Oral Health
- ☐ Hearing
- ☐ Vision
- ☐ Height and weight
- ☐ All the above

I ______________________________________, the parent/legal guardian of

_______________________________________, request that he/she be exempt from the state mandated annual school health screenings selected above for the current school year. I understand that this waiver to exclude my child must be renewed each school year or my child will be screened as mandated by the DHHS-School Health program guidelines. If parents/guardians opt out, the school must be notified and parents ARE REQUIRED TO PROVIDE AN EQUIVALENT SCREENING RESULT FROM A QUALIFIED MEDICAL/DENTAL PROFESSIONAL AT THEIR OWN EXPENSE, COMPLETED WITHIN THE PAST SIX MONTHS. If refusing height and weight screening parents only need to provide it to the school a signed and dated statement of refusal. This needs to be done each year if height/weight is refused.

For any questions please contact your school nurse or a designated staff.

____ _______________________

Signature of Parent/Legal Guardian Date