Name of Student:_____

Grade of above student:_____Date:_____

Every school year we offer dental, vision, and hearing screens free of charge. Please check Yes or No and sign at the bottom. You will not receive notices prior to these screenings. We plan on doing these screenings in the fall. If you change your mind after signing this form, please contact your school secretary or school nurse.

(Please check Yes or No for each exam)

TEST	YES	NO
DENTAL		
VISION		
HEARING		

Signature of Parent/Legal Guardian:

_____