



**Clarksville-Montgomery County School System
HEALTH SERVICES
CONSENT FOR VISION and/or HEARING SCREENING**

Student Name: _____ Grade: _____

School: _____ Teacher: _____

Your child has been referred for (vision/hearing) screening based upon a review of current classroom performance, past educational records and/or informal screening information (observation).

We are requesting permission to perform a non-invasive basic (vision/hearing) screening. Please note that this is only a screening and no diagnosis can be made with this testing. If a problem is noted, we recommend taking your child to a specialist of your choice for further evaluation.

Please sign and return this form to the school nurse. Your prompt reply would be appreciated as your permission is needed in order to screen your child. Please check one of the following:

_____ I give permission for a (vision/hearing) screening to be performed on my child.

_____ I do NOT give permission for a (vision/hearing) screening to be performed on my child.

Date

Signature of Parent/Guardian

If you have any questions please contact the school nurse.