LEMAN ACADEMY of EXCELLENCE

Health Office

Hearing/Vision Screening Opt-out Form

Scholar Name: _____ Birth Date: _____

I do not wish for my child to have the following screenings through Leman Academy of Excellence until further notice.

I understand that scholars who are enrolled, or applying for enrollment, within the Exceptional Scholar Services program are required to have an evaluation for hearing and vision each year. In this situation, a qualified healthcare provider is able perform this assessment, and a copy of their evaluation will be provided to the school.

Please check all that apply:

- HEARING SCREENING
- VISION SCREENING

I understand that I may change my mind at any time, and will do so in writing.

Parent or Guardian Signature: _____

Printed Name: _____

Date: _____