Parental Consent for Screening

Student name:_____Student ID:_____

Grade:_____ Date of Birth:_____ Date: _____

School Name:_____

Dear Parent/Guardian,

A team of educational professionals has recommended an initial screening for the following:

- ☐ Vision
- ☐ Hearing
- ☐ Occupational Therapy/ Physical Therapy
- ☐ Speech Language

This screener will be completed at no cost to you, and will help to determine if an evaluation and further assessment in that area is appropriate or needed. Once your consent is received, data will be gathered, screenings will be completed, and you will be contacted to discuss the findings. If you have any questions or concerns, please contact _____ at _____.

Please check the appropriate box below:

- ☐ I give consent to screen my child to determine if additional evaluation is required.
- ☐ I do not give consent to screen my child to determine if additional evaluation is required. (For Special Education referrals, consent for hearing and vision screenings are required)

_____ _____

Parent Signature Date