



**Avon Lake City Schools**

**Vision and/ or Hearing Screening Waiver.**

**Please print, complete, and return Attn. Nurse before November 11th if you DO NOT wish for your child to participate in screening.**

Date:

**Vision/ Hearing Screening Waiver**

School Year: 2020-2021

Child's Name: \_\_\_\_\_

Grade: \_\_\_\_\_

School: Avon Lake High School

I \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_, request that he/she be exempt from the state mandated annual school vision screening/ hearing screening monitoring for the current school year. I understand by choosing to exempt my child from the district vision/ hearing screening, I cannot hold the district liable in any way for any undetected changes in hearing/vision/vision health or for any related services/accommodations that he/she may not receive due to any unidentified changes in hearing or vision. I further understand that should I wish to revoke this waiver during the present school year, it is my responsibility to provide a written and signed note to the school nurse prior to the school's scheduled vision screening/monitoring.

\_\_\_\_\_  
Signature of Parent/Legal Guardian      Date

\_\_\_\_\_  
Printed Name of Parent/Legal Guardian

I **do not** want my child's vision to be screened.

I **do not** want my child's hearing to be screened.

This area for office use only: Received by: \_\_\_\_\_ Date: \_\_\_\_\_