



LYNCHBURG CITY SCHOOLS

**ANNUAL SCHOOL HEALTH SCREENING INFORMATION & OPT OUT**

Dear Parent/Guardian,

Please read the following on Hearing and Vision Screenings. These screenings are performed by your child’s school nurse throughout their academic career. Annually kindergarten, third, seventh, and tenth graders are given both hearing and vision screenings. If you choose to opt-out, please sign the bottom of this form and return it to the School Nurse. If after reading the following information, you choose to allow your child to participate in the screening process, please reach out to your School Nurse to arrange a time when you can bring your child to the school for their screening.

**Benefits of School Hearing Screening**

School-age hearing screenings are an integral tool in identifying children with hearing loss who were not identified at birth, lost to follow-up, or who developed hearing loss later. Without mandated routine hearing screenings in schools, students with unilateral, less severe, or late-onset hearing loss may not be identified or will be misdiagnosed and managed. Efforts to provide consistent protocols, screener training, and follow-up through school-age will help ensure that children with hearing loss are identified and managed in a timely manner, and thereby minimize negative academic consequences.

**Benefits of School Vision Screening**

Vision impairments in children are common and uncorrected vision problems can impair child development, lead to behavior problems in the classroom, interfere with early literacy and learning, and lead to permanent vision loss. Early detection and treatment are critical. Additionally, visual functioning is a strong predictor of academic performance in school-age children and vision disorders of childhood may continue to affect health and well-being throughout adulthood.

**I have read and understand the benefits of School Health Screenings. I do not wish to have my child participate in School Health Screenings at this time.**

I (parent name) \_\_\_\_\_, **DO NOT** give my permission for

(student name) \_\_\_\_\_ to participate in the vision/hearing screening administered during the 2020-21 school year.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date:

\_\_\_\_\_  
School Nurse Signature