Paradise Unified School District
Health Screenings Consent Form

_____
School Year

_____
Grade Level

_____
Date of Birth (i.e. 10/15/2001)

This authorization shall remain effective until revoked in writing and delivered to _____ school.
(Name of School)

My child, _____,
can participate in the following health tests:

a. Vision screening	☐ Yes	☐ No
b. Dental screening	☐ Yes	☐ No
c. Hearing screening	☐ Yes	☐ No
d. Scoliosis screening (abnormal lateral curvature of the spine)	☐ Yes	☐ No

_____
Parent/Guardian Name (please print)

_____
Parent/Guardian Signature

_____
Date

PLEASE RETURN THIS FORM TO THE SCHOOL IMMEDIATELY

If you have any questions, please contact your school's Health Secretary.