



# VISION HEARING SPEECH SCREENING



(check ✓ services requested)

*Please choose one of these*

- Vision Screen \$ 20.00
- Hearing Screen \$ 20.00
- Vision & Hearing Screen \$ 35.00
- I am choosing not to participate in this program and understand that I must furnish the school with a copy of the results of these tests if my child meets the criteria. These tests have been performed this calendar year and must be given to the school by the date of screening OR

*My child has a doctors appt. scheduled on \_\_\_\_\_ and I will give the results to the school the next day.*



- Speech Screen \$ 20.00
- =====
- Total Enclosed \$

Child's Name (printed) \_\_\_\_\_

Classroom \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you noted any problems in:  Vision  Hearing  Speech

Please explain:



*Parent Signature* \_\_\_\_\_ Date \_\_\_\_\_

Kindly return this form by Friday, October 5<sup>th</sup> to the Child's Day office with a check to:

## *"Child's Day"*