



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

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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, September 19th to the Child's Day office with a check to:

"Child's Day"