



Dear Parent:

As part of the School Readiness Project funded through the Department of Social Services, Office of Child Care Services, your child care provider/preschool/school will be hosting a Vision and Hearing Screening.

If you would like your child to take part in this screening, please fill out the information requested and sign the permission statements. You will receive a copy of the results of the screening.

Child's Last Name: _____ **First Name:** _____

Address: _____ **Telephone:** _____

City: _____ **State:** _____ **Zip:** _____

Birthdate: _____ full-term premature (by _____ weeks)

Currently wears eye glasses: Yes No

Family History of colorblindness: Yes No

Special Needs: _____

Physician: _____ **Family Eye Doctor:** _____

I give my permission to have my child participate in the Vision and Hearing Screening provided through the School Readiness Project.

Parent/Guardian Signature: _____ **Date:** _____

I give my permission to release any information obtained through the screening to staff at my child care provider/preschool/school.

Parent/Guardian Signature: _____ **Date:** _____

Name of child care provider/preschool/school child is attending: _____

Office - White; Center - Yellow; Parent/Guardian -White