**Office use only: H-R _____ L ____P.T._______**

**V ________**

**Date of screening: _________________________**

# Permission Form
# Vision and Hearing Screening

**Child's Name**: ________________________________________________________________

*(Please print legal name)*

**Date of Birth: ______________ Child Care Center: ____________________________________**

The Florida Department of Health and the Early Learning Coalition of Polk County have joined together to provide vision and hearing screenings for children 0-5 years of age. Primarily, children ages 2-5 will be screened, and children 6 months to 2 years of age may also be screened if time permits, or if a screening is requested. These screenings will be performed at your Child Care Center at no cost to you. **<u>You will receive a letter with the results of your child's screenings.</u>**

Parental permission is required to screen your child. Please complete this form.

**Yes _____** I give my permission for my child to participate in the vision and hearing screenings.

**No _____** I do not want my child to participate in the vision and hearing screenings.

Parent/Guardian (Print):_____________________________________________________________

Parent/Guardian (Signature): _______________________________________________________

Mailing address:____________________________________________________________________

Street City Zip code

E-mail address:_____________________________________________________________________

Date:___________________________ Daytime Phone Number: ___________________________

## Please return this form to your child care provider.

For further information call: Florida Department of Health–Polk (863) 393-5074 or (863) 701-4168.

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