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 6 months-5 years of age. (Children 6 months up to 1 year of age can be attempted to be screened as they may not cooperate due to their young age.) These screenings will be performed at your Child Care Center at no cost to you.

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

Certain medical conditions that your child may have will prevent them from being screened. If your child has a history of seizures, we cannot screen their vision. If your child has a pacemaker or vp shunt, we cannot screen their hearing. Please note below if your child has one of the mentioned medical issues.

Medical note: _____

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

____My child has glasses. ____Glasses are lost or broken. ___My child has ear tubes.
(If your child has glasses, please make sure they bring them on the day of the screening.)

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.