



Student Vision Screening Consent Form

Student's Name: _____ Birthdate: _____

Dear Parent/Guardian:

Good vision is essential to your child's learning. Children often do not complain of poor vision because they may have seen everything in the same manner for years and are not aware the world does not look the way they see it. As a free service, the school nurse will assess your child's vision using a standardized eye chart. The screening involves your child reading letters or identifying objects at a distance, and in some instances close up (referred to as near and far vision screening). In order for the nurse to conduct a vision screen on your child, prior consent is required.

A vision screening does not substitute for a comprehensive eye examination by an eye care practitioner. If you have any concerns about your child's vision, contact an eye care professional about an eye examination.

Please make a selection below, sign, date, and return this consent to the school nurse:

- ☐ **I GIVE consent** for the school nurse to perform a vision screening on my child.
- ☐ **I DO NOT give consent** for the school nurse to perform a vision screening on my child.

If you give consent and your child wears glasses or contacts, please be sure your child is wearing them on the day of the vision screening. You will be notified by letter **ONLY** if your child does not pass the screening or requires an eye exam.

X _____

(Signature of Parent / Legal Guardian/ Emancipated Student)

X ____ / ____ / ____

(Date signed)

This consent form will remain in effect for your child through graduation, departure and/or other termination of enrollment from a FCPS school, unless you revoke this consent in writing at any time, except any such revocation will not affect information that has already been released in reliance upon this consent.

PLEASE RETURN TO THE SCHOOL NURSE