BABOQUIVARI UNIFIED SCHOOL DISTRICT # 40

HEARING AND VISION SCREENING "OPT OUT" FORM

I _____ request that my student
(Parent/Guardian Name-Print)

_____Date of birth;_____
(Student's Name-Print)

not receive a hearing screening: _____
(Date)

not receive a vision screening_____
(Date)

_____
(Signature of parent/guardian) (Date)

This request shall remain in effect until the parent/guardian requests, in writing, that they wish to resume hearing and/or vision screening at Baboquivari Unified School District.