To be put on school letterhead and signed by principal

Health Screening Opt-Out Form 2025-2026

ONLY RETURN IF YOU <u>DO NOT</u> WISH YOUR CHILD TO BE SCREENED.

Dear Parents/Guardians,

In compliance with Florida Statute 381.0056 (4)(a), regarding school health services, we are notifying you that students in the St. Johns County School System will be offered the following health screenings:

Vision (Grades KG, 1^{st}, 3^{rd} and 6^{th})
Hearing (Grades KG, 1^{st}, and 6^{th})
Height/Weight (Grades 1^{st}, 3^{rd}, and 6^{th})
Scoliosis (6^{th} grade only)

These screenings are offered in an effort to decrease health barriers to learning and may be performed by school nurses, other school personnel, and trained volunteers. If your child is tested and the results are not in the "normal" range for the particular test, you will be notified by letter. **Your child will be screened unless you notify the school nurse, in writing by signing below, no later than _____________, that you do <u>not</u> want your child to participate.** It should be understood that such screenings do not substitute for a thorough examination by a health care provider.

We are pleased to be able to offer programs that support the health and well being of our students. Please contact ____________________ at _________________ if you have questions or concerns.

Sincerely,

(Principal/School Based Designee)

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ONLY SIGN BELOW AND RETURN TO THE SCHOOL NURSE IF YOU <u>DO NOT</u> WISH YOUR CHILD TO BE SCREENED.

Please **<u>DO NOT</u>** include my child,_______________________________, GRADE ______,

Teacher________________, in any of the health screening process (vision, hearing, height/weight, scoliosis):

____________________________	__________________________	____________
Parent Name (Printed)	Signature of Parent	Date