MEDARVA
Vision & Hearing Screening

SCREENING CONSENT FORM

I give permission for my child to participate in the free vision and hearing screening program provided by MEDARVA. I understand the following regarding this program:

1. **There is no charge for my child to participate in this screening program.**
2. **Children under the professional care of vision or auditory specialists can still participate in this non-invasive screening.**
3. **The information obtained from this screening is preliminary only and does not constitute a diagnosis.**
4. **I will be contacted by the Screening Program or by my child's teacher, school administrators, or directors should my child be referred for further evaluations. The results of the screening will be discussed with my child's teacher or program director in order to make sure accommodations are made.**
5. **I will not hold MEDARVA Vision and Hearing Screening Program accountable for any errors of commission or omission.**

PLEASE PRINT

PRINT NAME OF PARENT/GUARDIAN: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

School's Name: _____

Child's Name: _____

Date of Birth: _____ Sex: M F Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email: _____

In what language do you wish to receive verbal/written communications? _____

- ❑ My child is presently under the care of an eye care professional.
- ❑ My child is presently wearing eye glasses.
- ❑ My child has ear tubes.
- ❑ My child is being seen by an Audiologist or an ENT Physician (Otolaryngologist).

Please check the box below if you would like to opt-out of receiving communications from MEDARVA Healthcare: ☐