

Early Learning Coalition of Florida's Heartland, Inc.

PARENT CONSENT FORM FOR HEARING, VISION, HEIGHT/WEIGHT SCREENING

Child's name _____ Date of birth _____ M__ F__

Child care program:

Does your child have:

Ear tubes? Yes _____ No _____

History of ear infections? Yes _____ No _____

Current ear infection? Yes _____ No _____

Does your child wear:

Glasses? Yes _____ No _____

Hearing aid? Yes _____ No _____

I give my permission for my child to have vision, hearing, height and weight screenings (height and weight screening for 2-5 yr olds only) completed by the Early Learning Coalition Screening Staff. I understand that the results of these screenings will be made available to me following the screening. I understand this test is performed free of charge.

Parent signature _____ Date _____

Parent name printed _____

*Daytime phone number of parent (_____) _____ - _____

*Optional (your number will not be released to any one and will be used for the sole purpose of follow-up by the ELCFH Health Specialist.)

____ I do not wish to have my child screened at this time. I understand the testing is free, and that I may consent to testing at a later time.

Parent signature _____ Date _____

Parent's printed name _____

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