Phone: (215)
Fax: (215)

Date: _____
Month / Date / Year

Please complete the following and return to your child's school.

I do _____ give permission, I do not _____give permission for my child, _____
(child's full name)

to receive vision screening. I understand that the results of the vision screening and necessary additional information about my child that may be in his/her school records may be shared with other educators and health care professionals working with the schools to provide appropriate follow-up services for my child.

_____
Signature of Parent or Legal Guardian

Date: _____
Month / Date / Year

电话: (215)
传真: (215)

日期: _____
月／ 日 ／年

请将以下部分填好并递交子女就读之学校。

我同意_____ 我不同意_____
我的子女 _____
(子女姓名)

接受眼科普查。我知道这次眼科普查的结果以及其它在学校档案中的有关我子女的必要信息，可能被转交给其他教育工作者以及与学校合作的医疗工作者，以便对我的子女提供恰当的后续服务。

_____
家长或合法监护人签字

日期: _____
月／ 日 ／年