BISMARCK PUBLIC SCHOOLS
College, career, community ready

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SELECTIVE SCREENING: PRIOR NOTICE AND CONSENT

Name:_____ DOB:_____

Parent:_____ Date:_____

Address:_____ Phone:_____

Teacher:_____ School/Gr:_____

With your permission, a selective screening will be conducted with your child to determine if there are any concerns with his/her growth/development, hearing, or vision. This screening is recommended for the following reasons:_____

_____

_____

This screening will include the following:

☐ Vision Procedure:_____

☐ Hearing Procedure:_____

☐ Fine Motor Procedure:_____

☐ Gross Motor Procedure:_____

☐ Speech/Lang. Procedure:_____

☐ Cognition Procedure:_____

☐ Behavior Procedure:_____

☐ Other Procedure:_____

Student Referred By:_____

Screening To Be Conducted By (Title or Position):_____

PLEASE CHECK THE ANSWER TO THE FOLLOWING STATEMENT:

YES ☐ NO ☐ I understand the reason for the proposed screening of my child, and CONSENT to the screening. I understand that my consent may be revoked at any time.

If you agree to have your child participate in this screening, please sign/date this form and return it to:

_____

_____

Signature of Parent/Guardian Date