



DISTRICT HEALTH SERVICES

13801 E Benson Highway · P.O. Box 800 · Vail, AZ 85641 · 520-879-2010 •
Fax: 520-879-2301

I OPT my child, _____
out of school vision and hearing screenings for this school year.

I understand that by doing so I will be required to provide my child's yearly
screening information from a physician or specialist to my child's school,
and this must be done every year.

Parent/Guardian signature

Date