

**PARENTAL CONSENT  
FOR SCHOOL HEALTH SCREENING  
PROCEDURES**

I hereby give my consent for my child/children,

---

*(name of child/children)*

To participate in the health screenings conducted by the County Public Health Nurse. The screening procedures may include:

Scoliosis  
Vision  
Hearing  
Height  
Weight  
Blood Pressure

---

Parent or Guardian

---

Date