

**RICHMOND COUNTY SCHOOL SYSTEM
PSYCHOLOGICAL SERVICES**

Central Office—3rd Floor
864 Broad Street
Augusta, GA 30901
Office (706) 826-1131 • Fax (706) 826-4634

PARENT PERMISSION FOR HEARING/VISION SCREENING

(NAME OF SCHOOL)

TO: RCSS Department of Psychological Services-(ONLY)

I hereby grant permission for my child, _____
(Name of Child) (Date of Birth)
to have his/her hearing and vision screened, so that the Response to Intervention/Student Support Team (RtI/SST) can better assist him/her. This screening will be conducted at your child's school by either the school nurse or other appropriately trained school personnel, at no expense to you.

I (do ___) (I do not ___) wish to be informed of the results of the screening.

Parent or Legal Guardian's Signature

Date

Parent(s) Name (please print legibly)

Address

City

State

Zip Code

Home/Cell Phone No.

Work Phone No.

"Learning Today... Leading Tomorrow"

The Mission of the Richmond County School System is to educate students to become lifelong learners and productive citizens.