SPECIAL NEEDS WAIVER of REFERRAL INFORMATION

I, (print name) ____________________________________________,
decline information about sources for □ hearing screening, □ vision screening,
and/or □ learning diagnosis

offered by (name of program) ____________________________________________
on (date) ________________________________

______________________________________________________________
Signature of Student/Parent or Guardian* Date

______________________________________________________________
Signature of Program Representative Date

*Students under the age of 18 must have this consent form signed by the student’s parent or guardian.