NORTH Dakota | Health & Human Services
Be Legendary.

BEST IN CLASS
Health Screenings
Permission Form

Child's Name _____ STARS State ID (for program use only) _____

The BEST IN CLASS program is committed to ensuring children are healthy. Screenings are important to ensure the overall health and well-being of your child. Health screenings are offered at no cost to you.

Please check the screenings you agree to allow a qualified professional to administer. You may choose to opt out of some or all the screenings if you do not wish for your child to participate.

I agree that my child may participate in the following screenings:

___**Vision** (checking for visual accuracy)

___**Dental** (using a flashlight/small mouth mirror to look for any signs of dental disease)

___**Hearing** (using an audiometer to measure hearing)

___**Physical** (measuring height, weight, blood pressure, BMI calculation)

___**All of the above**

If documentation of a child's well visit from a physician, dentist, or eye doctor is provided within 12 months of the first day of attendance this may serve in place of screenings.

____**My child has been seen within the past 12 months by our primary provider (physician/dentist/eye doctor) and documentation of the visit is attached.**

_____**I do not want my child to participate in any health screenings.**

Parent/Guardian Signature_____ Date_____