**Health Service Authorization Form**
**2024-2025**

I hereby give my consent to Youngstown Community School for my child, (first and last name)_____, to receive the following health services.

1. Hearing
2. Vision

Vision and Hearing Screenings will begin in the fall for students in grades K,1,3,5,7. Students new to the school district will also be screened regardless of their grade.

You will be notified of your child's hearing screening results. If your student fails the vision screening you will be notified of the results.

Please contact the school to speak to the school nurse at 330-746-2240.

Thank you,
Ms. Payich

Signature of Parent/Guardian: _____
Date: _____