Parental Notification
School Health Assessments 2017-2018

From time to time during the year, health screening may be provided through a contract with the South Dakota Department of Health (DOH), which is subject to the rules and regulations of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that the DOH provide access to our Notices of Privacy Practices. You may view the DOH notice on our website at https://doh.sd.gov/documents/HIPAANotice.pdf
or request a printed copy by contacting us at 1-800-305-3064.

Screenings that will be provided during the 2017-2018 school year include:

- Vision Screening for students in Grades **K, 2, 5, 8 & 10**
- Hearing Screening for students in Grades **K, 5, 9 and all new students in the School District**
- Physical Assessments for students in Grades **K & 5**
- Scoliosis Screening for girls in Grades **5 & 7**
- Scoliosis Screening for boys in Grades **8**

Abnormal curvature of the spine is usually first noticed at the beginning of the adolescent growth spurt. Often early detection and appropriate treatment can prevent progression. The screening procedure takes about 30 seconds and does require the student to remove his/her shirt or blouse in order that the spine can be visually observed by the Community Health Nurse.

A child **not** included in the grades/service listed above can be screened with the written consent of the parent/legal guardian.

Parents will be notified of any concerns identified during the health screenings so their child can be further evaluated by the provider of the parent's choice.

When a vision or hearing screening indicates additional testing is needed, the nurse can discuss with school personnel the possible accommodations in the classroom that can be made for the benefit of the child.

If you agree to your child's participation as indicated above, there is no need to sign or return this form to the school.

To Decline Services

_____ I agree to have my child participating in health screening, but do **NOT** want an abnormal hearing or vision screening result to be shared with school personnel

_____ I decline to have my child participate in school health screening

_____ (Printed name of student)

_____ (Printed name of parent)

_____ (Parent Signature)