

# Due West Elementary School

## Cobb County School District

*"A community with a passion for learning"*



**Peggy Fleming**  
*Principal*

STUDENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Dear Parents:

The following letter is to inform you about the VISION SCREENING PROGRAM conducted for our students. We want you to understand that this is not a substitute for a complete vision examination, but rather serves as a method for us to screen our students and suggest further care for those who may have problems with their vision.

We are requesting permission to perform a vision screening with your child at your child's school. If your child is able to pass this screening, no further information will be sent to you. However, if your child is unable to pass the vision screening, a letter will be sent to you in approximately three weeks advising you of the results and recommendations.

Thank you for your assistance.

Sincerely,

Examiner's Signature

I hereby grant my permission for the following:

1. The vision screening of my child by the representatives of the Cobb County School District.
2. The release of the screening information to Cobb County School District staff, officials, and to the Cobb County School District Vision Consultant, Dr Stephen Rothbloom.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return to your child's teacher.