**BEDFORD COUNTY SCHOOLS**
**REFERRAL FOR INDIVIDUAL SCREENING**

**Student: _____ Grade: _____ School: _____**

**Parent: _____** **Date of Screening Referral: _____**

**Teacher: _____** **Date Sent: _____ Date Received:_____**

The area to be considered for your child's Individual Screening is:

☐ 1 Vision/Hearing Screening

PLEASE CHECK ONE OF THE FOLLOWING!

_____ I give permission for an Individual Screening.

_____ I do not give permission for an Individual Screening.

Date: _____ Signature of Parent or Guardian: _____

Phone: _____ Address: _____

Comments:_____

_____