

**MANDATORY HEALTH SCREENINGS OPT OUT FORM  
SCHOOL YEAR: 2020-2021**

Dear Parent/Guardian,

Throughout a typical school year, multiple health screenings required by the state of New Jersey are conducted. As per, N.J.A.C. 6A:16-2.2(g)3 and N.J.A.C. 6A:16-2.3(b)3ii mandated health screenings include height, weight, blood pressure, hearing, vision, and scoliosis.

The grades in which these screening must be carried out are as follows:

| <b>Mandated Screenings</b>                               |               |               |                       |               |                |                  |
|--|---------------|---------------|-----------------------|---------------|----------------|------------------|
| <b>Required Grade Level</b>                              | <b>Height</b> | <b>Weight</b> | <b>Blood Pressure</b> | <b>Vision</b> | <b>Hearing</b> | <b>Scoliosis</b> |
| <b>K – 12</b>  | <b>X</b>      | <b>X</b>      | <b>X</b>              |               |                |                  |
| <b>K – 2, 4, 6, 8, 10</b>                                |               |               |                       | <b>X</b>      |                |                  |
| <b>K – 3, 7, 11</b>                                      |               |               |                       |               | <b>X</b>       |                  |
| <b>Biannually for students between 10 – 18 years old</b> |               |               |                       |               |                | <b>X</b>         |

Please note that many of these screenings are typically a part of the physical for sports, entry to school or annual well visits. Health screening information provided on these documents that were submitted this year will satisfy the mandatory requirements.

**Some school- based screenings may have already been completed; however you may opt-out of these state required screenings by signing below.**

If your student is **a remote learner** and you choose not to opt-out of the mandatory screenings, please **contact your school nurse to make an appointment.**

Please return this opt-out form to your school nurse by \_\_\_\_\_.

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**I choose to opt my student out of health screenings for the 2020-2021 school year.**

Parent/ Guardian

Signature \_\_\_\_\_ Date: \_\_\_\_\_