MALDEN PUBLIC SCHOOLS
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Student Opt-out permission form for yearly health screening SY 2025/2026

Student/Name_____

School_____ Date of Birth_____

Grade_____ Homeroom_____

Parent/Guardian (print) _____

Signature_____ Date _____

*My signature indicates I **do not** want my student to participate in the following screening(s)

Please check all that apply:

- ☐ Vision - grade K to 5 , 7 and 10
- ☐ Hearing - grade K to 3, 7 and 10
- ☐ BMI - Height and Weight grades 1, 4, 7 and 10
- ☐ Postural Screening - grades 5 to 9