

ASQ Permission to Screen

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Florida Department of Children and Families License # C07SJ0083

_____ I give permission for my child to participate.

_____ I do NOT give permission for my child to participate.

Print Child's Name: _____

Print Parent's Name: _____

Child's DOB: _____ If premature, original due date: _____

The results of this screening are for internal use only and will be used to guide lesson plans and activities for the classroom. Any further medical assistance, advice and treatment will be between you and your medical provider.

Parent/Guardian Signature

Date