ORANGE TOWNSHIP PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL SERVICES

451 Lincoln Avenue Orange, New Jersey 07050 (973)-677-4027 fax (973)-677-4035

Barbara L. Clark, Director **Thomas N. Kennedy, Supervisor**

PERMISSION TO IMPLEMENT HEARING AID CHECKS

STUDENT'S NAME: _____ DATE: _____

REFUSAL:
I will maintain full responsibility for the hearing aids of my child. This will include hearing aid checks, maintenance, and follow-up.

Signature: _____ Date: _____

ACCEPTANCE:
I hereby give my permission to implement a hearing aid check for my child by district personnel.

The hearing aid checks will occur _____ and be the responsibility of_____

_____.

PLEASE NOTE: The district will assume responsibility for the equipment it owns and the parent(s) will be responsible for personal aids they have purchased.

Signature: _____ Date: _____