

## SBIRT Screening Opt Out Form

Please sign and return this form only if you **Do Not** want your child to participate in the SBIRT Screening. Please complete a separate form for each child if you have two or more students in the 9<sup>th</sup> grade.

### COMPLETE THE FOLLOWING INFORMATION

Child's Name: \_\_\_\_\_  
(Last) (First)

My Child's School Identification Number: \_\_\_\_\_

If unknown, please include your child's Date of Birth: \_\_\_\_\_

Name of Parent/Guardian/Custodian: \_\_\_\_\_  
(Please Print)

Signature of Parent/Guardian/Custodian:

\_\_\_\_\_

Contact Information (Telephone/Cell Phone): \_\_\_\_\_

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

**IMPORTANT: Please turn in directly to the Nurse's Office or send PDF file to [childs@pathfindertech.org](mailto:childs@pathfindertech.org) prior to the SBIRT screening. Without this form, your son /daughter will be screened.**

Thank you for your attention.

April Childs RN, BSN