**Lista dzieci - zgoda na badanie przesiewowe widzenia w roku szkolnym 2024-2025**

(Badanie w ramach Słupskiego Programu Profilaktyczno-Terapeutycznego dla dzieci słabowidzących i słabosłyszących.)

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| **Lp.** | **Imię i nazwisko dziecka** | **Data urodzenia** | **Podpis rodzica/prawnego opiekuna** | **Tel. kontaktowy** | **Uwagi diagnostyczne** |
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