MARYVILLE CITY SCHOOLS COORDINATED SCHOOL HEALTH
STUDENT HEALTH SCREENING FORM

STUDENT NAME: _____

SCREENING DATE: _____ **SCHOOL:** _____

BIRTHDAY: _____ **GENDER:** _____ **GRADE:** _____

Height: _____ in. Weight: _____ lbs. **Blood Pressure**: _____ / _____

Dental Score: 1 2 3 **Scoliosis** (grade 6): Pass / Fail

Vision

	Right	Left	
Near	Acuity 20/_____	Acuity 20/_____	Glasses / Contacts (circle only if wearing) Glasses: Broken / Lost / Not wearing / Refuses to wear (circle if appropriate)
Far	Acuity 20/_____	Acuity 20/_____	

PureOptix Participation: Yes / No Color Perception (grade K): Pass / Fail

Hearing (pass or fail)

	Right	Left	
1000 Hz	_____	_____	Circle if appropriate: History of hearing loss and/or surgery
2000 Hz	_____	_____	PE Tubes Hearing Aid(s)
4000 Hz	_____	_____	

RESCREEN INFORMATION

Blood Pressure Systolic _____ Diastolic _____ Date_____ Time_____

Systolic _____ Diastolic _____ Date_____ Time_____

Vision

	Right	Left
Near	Acuity 20/_____	Acuity 20/_____
Far	Acuity 20/_____	Acuity 20/_____

Glasses / Contacts (circle only if wearing)

Date_____

Hearing (pass or fail)

	Right	Left
1000 Hz	_____	_____
2000 Hz	_____	_____
4000 Hz	_____	_____

Date_____

Screening Notes/Comments: _____

_____

Screening Requested by _____ Date(s) Absent _____

Source: TN School Health Screening Guidelines 2015. Form Revised August 2018.