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Section VIII - Screening Programs

Table of Contents (cont'd)

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

DENTAL SCREENING GUIDELINES

These guidelines, based in large part on similar guidelines developed by the California Dental Association, were written to answer basic questions about dental screening programs. They are recommended for use by dentists and others who wish to participate in screenings as part of the Children's Dental Disease Prevention Program (DDPP).

Objectives

- To facilitate early detection and treatment of dental disease.
- To reduce the incidence and impact of dental disease.
- To make parents aware of their children's dental problems.
- To increase the dental awareness of the public.
- To encourage the establishment of effective dental health practices early in life, including regular professional care.
- To promote a positive image of dental health professionals.

DENTAL HEALTH EVALUATION

A dental health education program will be given yearly to all first grade classes.

If another organization is presenting a dental program i.e. Young & Healthy, the nurse will work in conjunction with them to perform dental assessment as needed.

Community dental clinics may be offered for eligible students during the school year. Nurses may screen for referrals as time permits.

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

DENTAL SCREENING PROCEDURE

Procedure:

1. Pupils in grades K-5 may be screened for dental disease (Health and Safety Code No. 361)
2. A written referral will be sent to parents of pupils requiring dental care
3. Assist parents when indicated

Equipment Needed:

1. Tongue blade/applicators
2. Flashlight
3. Forms required:
   a. A dental screening list
   b. Dental referral forms
   c. Health Record

Screening Procedures:

1. If screening is done by other than a district school nurse, a parent notification letter must be sent home prior to screening (sample attached.)
2. Arrange a convenient time and place to screen with the teacher. Screening may be done in the classroom or the Health Office.
3. Examine the mouth for the following problems/abnormalities:
   a. Obvious caries
   b. Abscesses (inflamed, swollen areas at the gum line)
   c. Extra teeth
   d. Malocclusion
   e. Teeth which obviously need a professional cleaning
4. Send the dental referral form home with findings
5. Note findings on health record. Indicate if teeth have been repaired or are in the process of dental attention (i.e., fillings, orthodontia, etc.)
6. Follow-up as necessary

PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER . HEALTH PROGRAMS

_____
Date

Dear Parent/Guardian:

Dental screenings will be provided at your child's school by a volunteer dentist during the month of_____.

The children with severe dental problems who have no dental insurance will be referred to the USC Dental Van during the week of_____. This service is free and available through Young and Healthy for Pasadena Unified School District students.

If you do not wish to have your child screened, please indicate this in writing to the school principal immediately.

Sincerely,

Ann Rector
Director of Health Programs

351 South Hudson Avenue · Pasadena, CA 91109
(626) 795-6981 ext. 249 · Fax (626) 584-1540
www.pasadena.k12.ca.us · www.pusd.us

PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER . HEALTH PROGRAMS

_____
Fecha

Estimado Padre/Tutor:

Un dentista voluntario le dará examenes dentales a su niño, en la escuela, durante el mes de_____.

Los niños con problemas dentales severos, quienes no tengan seguro dental, serán recomendados a la Unidad Ambulante Dental de la USC durante la semana del _____.

Si no desea que su niño sea examinado, por favor indíqueselo inmediatamente por escrito al director/a de la escuela.

Cordialmente,

Ann Rector
La Directora de los Programas de Salud

351 South Hudson Avenue · Pasadena, CA 91109
(626) 795-6981 ext. 249 · Fax (626) 584-1540
www.pasadena.k12.ca.us · www.pusd.us

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

DENTAL SCREENING CLASS LIST

Teacher_____ Room #_____ Grade _____

Name of Pupils	No Visible Caries	Caries Primary Teeth	Caries Permanent Teeth	Abscess	Cleaning Needed	Condition of Gums	N = No Visible Caries R = Repaired A = Urgent B = Routine	Date Checked	Date Referred
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									
16.									
17.									
18.									
19.									
20.									
21.									
22.									
23.									
24.									
25.									

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

REPORT OF DENTAL SCREENING EXAMINATION

SCHOOL_____ Date of Screening _____

Name_____I.D. #_____Birthdate _____

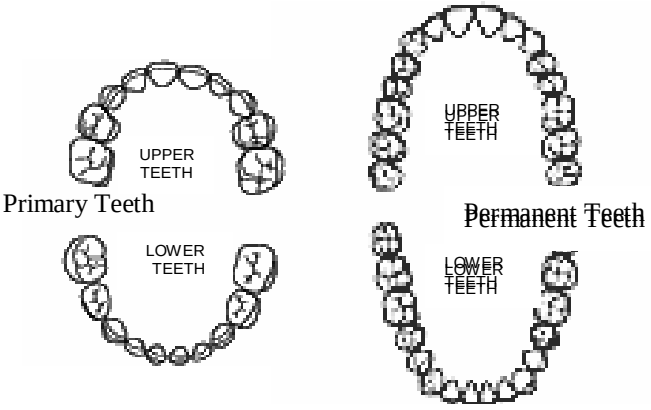
Address_____Telephone _____

Grade/Teacher _____

_____ 1. One or more teeth with cavities.

_____2. Crooked or irregular teeth or faulty bite.

_____3. Teeth need professional cleaning.



THE SCREENING EXAMINATION RATES THE PRIORITY OF DENTAL CARE AT THIS TIME TO BE:

_____A. Urgent (Child should be seen by dentist as soon as possible.)

_____ B. Routine (Child should be seen by dentist within six months.)

*** Call your school nurse for dental referrals.**

SPECIAL COMMENTS _____

School Nurse:_____Date _____

Phone Number: _____

To be completed by the DENTIST:

The following dental work was completed:

1. Cleaning and prophylaxis
2. Cavities repaired
3. Child under treatment for dental problems

Please sign and return this form to the Nurse at:
(Please stamp School Address here)

Signature_____D.D.S.

Please print name _____

Address _____

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

REPORTE DEL EXAMEN DE OBSERVACION DENTAL

ESCUELA_____ Fecha de Observacion _____

Nombre_____I.D. #_Fecha de nacimiento _____

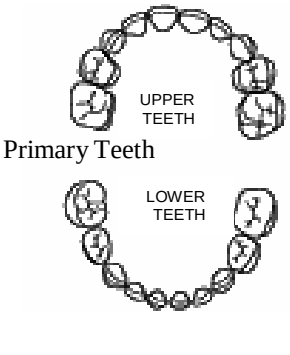
Domicilio_____Telefono _____

Grado/Maestro _____

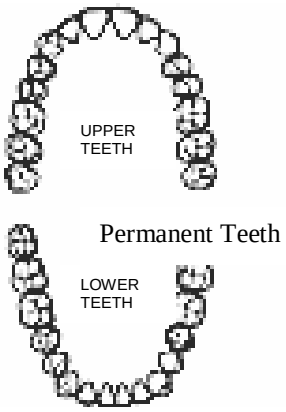
_____1. Uno o mas dientes tienen caries.

_____2. Dientes torcidos o irregulares o masticar defectuoso.

_____3. Los dientes necesitan limpieza profesional.



Primary Teeth



Permanent Teeth

EL EXAMEN DE OBSERVACION INDICA QUE LA PRIORIDAD DEL CUIDADO DENTAL EN ESTE TIEMPO ES:

_____A. Urgente (El nino debe de ver a un dentista tan pronto como sea posible.)

_____B. Rutina (El nino debe de ver a un dentista dentro de seies meses.)

***Para referencias dentales llame a su enfermera escolar.**

COMMENTARIOS ESPECIALES _____

Enfermera Escolar:_____Fecha _____

To be completed by the DENTIST:

The following dental work was completed:

1. Cleaning and prophylaxis
2. Cavities repaired
3. Child under treatment for dental problems

Please sign and return this form to the Nurse at:
(Please stamp School Address here)

Signature_____D.D.S.

Please print name _____

Address _____

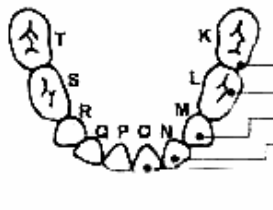
PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

REPORT OF DENTAL SCREENING

Student:_____ ID #_____ DOB_____ Grade/Teacher _____

School Nurse_____ School_____ Date _____

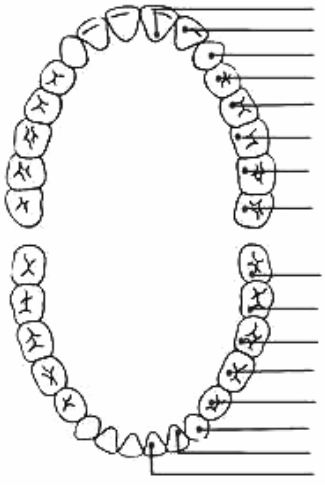
Primary Teeth



Upper Teeth	Erupt	Shed
Central Incisor	8-12 mos.	6-7 yrs.
Lateral Incisor	9-13 mos.	7-8 yrs.
Canine (Cuspid)	16-22 mos.	10-12 yrs.
First Molar	13-19 mos.	9-11 yrs.
Second Molar	25-33 mos.	10-12 yrs.

Lower Teeth	Erupt	Shed
Second Molar	23-31 mos.	10-12 yrs.
First Molar	14-18 mos.	9-11 yrs.
Canine (Cuspid)	17-23 mos.	9-12 yrs.
Lateral incisor	10-16 mos.	7-8 yrs.
Central incisor	6-10 mos.	6-7 yrs.

Permanent Teeth



Upper Teeth	Erupt
Central Incisor	7-8 yrs
Lateral Incisor	8-9 yrs
Canine (Cuspid)	11-12 yrs
First Premolar (First Bicuspid)	10-11 yrs
Second Premolar (Second Bicuspid)	10-12 yrs
First Molar	6-7 yrs
Second Molar	12-13 yrs
Third Molar (Wisdom Tooth)	17-21 yrs

Lower Teeth	
Third Molar (Wisdom Tooth)	17-21 yrs
Second Molar	12-13 yrs
First Molar	6-7 yrs
Second Premolar (Second Bicuspid)	10-12 yrs
First Premolar (First Bicuspid)	10-11 yrs
Canine (Cuspid)	11-12 yrs
Lateral Incisor	8-9 yrs
Central Incisor	7-8 yrs

_____ Dental Education Given

Symptoms/Comments _____

_____

_____

Dental Providers Who Accept Denti-Cal or Medi-Cal

Proveedores de dentales que acepta Denti-Cal o Medi-Cal

91101

Maria Cabalinan, D.D.S.
668 N. Los Robles Avenue
Pasadena, CA 91101
(626) 405-9090
Languages Spoken: Spanish, Tagalog

Century Dental Centers
115 S. Los Robles Avenue
Pasadena, CA 91101
(626) 795-8628
Languages Spoken: Spanish and Mandarin

Dental Plus
310 S. Lake Avenue
Pasadena, CA 91101
(626) 795-6855
Languages Spoken: Spanish, Armenian, Tagalog, Farsi, Burmese, Mandarin, Vietnamese, Hungarian, Arabic, French

Newport Dental
81 N. Lake Avenue
Pasadena, CA 91101
(626) 440-0240
Languages Spoken: Spanish, Armenian, Chinese, & Tagalog

Smart Dental Care
742 E. Colorado Blvd.
Pasadena, CA 91101
(626) 405-0707

Lena Zerounian, D.D.S.
65 N. Madison Avenue, Suite 701
Pasadena, CA 91101
(626) 795-2900
Languages Spoken: Spanish, Armenian, & Arabic

91103

Altadena Dental Center
2036 Lincoln Avenue
Pasadena, CA 91103
(626) 797-6555
Languages Spoken: Spanish, Russian, & Armenian

Community Health Alliance of Pasadena (CHAP)-Fair Oaks Dental Clinic
1855 N. Fair Oaks Avenue
G-Floor, Suite 100
Pasadena, CA 91103
(626) 398-5970
Languages Spoken: Spanish & Tagalog

91104

Allen and Washington Dental Office
1864 E. Washington Blvd., Suite 102
Pasadena, CA 91104
(626) 791-7474

Raffi Malkounian, D.D.S.
1330 Sinaloa Avenue, Suite 201
Pasadena, CA 91104
(626) 794-0620
Languages Spoken: Arabic, Hungarian, & Russian

Vicki Wang, D.D.S.
1282 N. Lake Avenue
Pasadena, CA 91104
(626) 797-3451
Languages Spoken: Spanish & Korean

91105

Reynaldo Barbon, D.D.S.
109 W. California Blvd.
Pasadena, CA 91105
(626) 844-7778
Languages Spoken: Spanish & Tagalog

Altina Karimyan, D.D.S.
800 Fairmont Avenue, Suite 100
Pasadena, CA 91105
(626) 304-3004
Languages Spoken: Spanish

91106

Pacita Franco, D.D.S.
324 N. Allen Avenue
Pasadena, CA 91106
(626) 795-6566
Languages Spoken: Tagalog

Karen Guinn, D.D.S.
1175 E. Green Street
Pasadena, CA 91106
(626) 578-1687
Languages Spoken: Spanish

Kids Dental Care
1127 E. Green Street
Pasadena, CA 91106
(626) 389-2570
Languages Spoken: Spanish

Walnut Hill Dental Group
181 N. Hill Avenue
Pasadena, CA 91106
(626) 796-0313
Languages Spoken: Spanish, Armenian, Russian, & Tagalog

91107

Kim Hong, D.D.S.
2379 E. Colorado Blvd.
Pasadena, CA 91107
(626) 584-7017
Languages Spoken: Spanish & Korean

Washington Dental Group
2554 E. Washington Blvd.
Pasadena, CA 91107
(626) 296-0056
Languages Spoken: Spanish

Los Angeles County

Pediatric & Family Medical Center
1530 S. Olive Street
Los Angeles, CA 90015
(213) 747-5542
Languages Spoken: Spanish

Further Information

Dental Society - (626) 285-1174
Medi-Cal - 1(800) 322-6384
PCC Dental Clinic - (626) 585-7241

Orthodontic Clinics

Eisner Pediatric & Family Center

The Eisner Pediatric & Family Medical Center provides **orthodontic services** for our young patients during one week of the month.

As your children grow older and develop more teeth, the dentist will begin taking x-rays during their six-month visits. This allows her to see changes even before they appear above the gum level.

During checkups, the dentist will:

- Examine your child's bite by looking at how evenly the top and bottom teeth fit when the mouth is closed
- Recommend braces when they're needed to straighten teeth, fix gaps between the teeth, or make your child's bite even

In children, braces often are recommended to guide proper jaw growth. Hopefully, the result is that the child's permanent teeth come in straight.

Orthodontics for Cleft Lip & Palate Repair

Every month, for three days, EPFMC's Dental Clinic patients receive the services of orthodontist Juliana Panchura, DMD, and her team. Dr. Panchura flies in from Oregon each month to perform orthodontic care for patients who have had cleft lip or palate reconstructive surgery. We're the only clinic in the area that offers this service.

About 200 EPFMC patients are under Dr. Panchura's care, and there is a waiting list of others who want to see her. If you or child needs these services, the state pays for them for patients up to the age of 21.

1530 S. Olive St.
Los Angeles, CA 90015
(213) 747-5542
Bilingual English/Spanish

USC School of Dentistry 925
W. 34th St., Room 318 Los
Angeles, CA 90089
(213) 740-0406 George or Glenda
Bilingual English/Spanish
Work done by dentist serving residency & instructor
Age: Children & adults
Fee: Insurance & family plan (Will not accept Medi-Cal or HMO)
$2,800-3,500 Includes retainers & 2yrs of check-ups Extractions,
fillings, oral surgery, and specialty referrals extra
$10 Screening available - will be given 2 options for care. Then talk to financial screeners. Credit check run. Relative can co-sign.

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

FIRST GRADE DENTAL HEALTH PROGRAM

GOAL:

To assist in learning how to keep their teeth healthy

OBJECTIVES:

The student will be able to:

1. List the parts of the tooth
2. Demonstrate proper tooth-brushing technique
3. List 4 ways to keep teeth healthy
4. Demonstrate an understanding of tooth safety

MATERIALS:

1. Video - "Tooth Brushing With Charlie Brown" (5 minutes), "The Sparkles' Space Adventure" (8 minutes), "Haunted Mouth" (13 minutes), or other approved video.
2. Toothbrushes or other materials (see below)
3. Dental model and large toothbrush (check out)

RESOURCES:

1. Colgate Bright Smiles Program
2. PREPARATION:

a. Make arrangements to pick up materials at the Ed. Center

b. Schedule classes with first grade teachers

c. Notify principal of class schedule

*Please request these samples directly from Colgate:

http://www.colgate.com/en/us/oc/bright-smiles-bright-futures/program-materials/for-teachers

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

OUTLINE OF LESSON PLAN

I. PARTS OF A TOOTH

A. ENAMEL - covers crown of tooth, the part you see above gum line. Hardest substance in the body.

B. DENTAL PULP - soft tissue in the middle of the tooth. Contains blood vessels and nerves.

C. DENTIN - forms the body of the tooth--hard tissue.

D. CEMENTUM - tissue which covers the root and holds the tooth in place--hard substance.

E. GUM TISSUE - Helps anchor teeth to bones of jaw - healthy gums are pink in color.

II. TOOTH DECAY

A. How cavities start:

1. Plaque - invisible film constantly forming on teeth
2. Sugar - from the foods we eat
3. Acid - formed from the combination of sugars and plaque will attack teeth dissolving tooth enamel

III. KEEPING TEETH HEALTHY

A. Good diet

1. Good foods
2. Bad foods
3. Role of sugar

B. Brushing

1. Frequency
2. Technique
3. Toothpaste and the role of flouride
4. Type of toothbrush - soft with round bristles
5. What to do when you don't have a brush
   a. Swish and swallow
   b. Finish meal with fruit or vegetable

C. Flossing

1. Technique
2. Frequency

D. Dentist

1. Frequency
2. What happens at the dentist
    a. X-rays
    b. Cleaning
    c. Fluoride
    d. Filling if necessary

IV. TOOTH SAFETY

A. Drinking fountain safety

B. Sucking thumb

C. Mouth Injuries

HEARING SCREENING GUIDELINES

A. SCREENING: (CEC. Title 17, Public Health Section 2951 and CEC 49455)
The school nurse shall conduct puretone audiometric screening on all pupils who are:

1. New to the district
2. Enrolled in special education
3. Referred by the classroom teacher
4. Known to have a hearing deficit from previous testing
5. Enrolled in K or 1st, 2nd, 5th, 8th grades

B. PROCEDURE:

1. Arrange with specific teachers and administrators for time, date, and place screening will occur. DO THIS AS EARLY IN THE SCHOOL YEAR AS POSSIBLE.
2. Obtain class rosters for recording purposes.
3. Set up audiometer in as quiet a spot as possible. Check equipment to ensure proper functioning each day it is used.
4. Place earphones on child, be sure the RED earphone is on the right ear and the BLUE is on the left.
5. Child should not be able to see the face of the audiometer or your hand movements.
6. Administer a sweep-check screening test.

   Screening is done at the frequencies 1000, 2000, and 4000 Hz at a hearing level of 25 decibels.

   Set the frequency selector dial at 1000 Hz and the hearing level dial at 50 dB. Present the tone one or two times at 50 dB to orient the child and assure a response to the correct signal. Once you have received the response (hand raised) reset hearing level dial at the 25 dB setting for the remainder of the screening test. Make sure that you do not fall into rhythmical patterns when operating the interrupter switch. Complete the sweep screening test in the following manner:

   a. Test the right ear at 1000, 2000, and 4000 Hz
   b. Switch the tone to the left ear leaving the frequency selector at 4000 Hz
   c. Test the left ear at 4000, 2000, and 1000 Hz
   d. Record the results and dismiss the child

   If the child fails to hear any tone at 25 dB, immediately perform the first *threshold* test at the failed frequencies only. However, it is not advisable to do thresholds during mass screening. Parents may be contacted at any time to discuss testing results.

   *Thresholds may be done by certificated audiometrists only.

7. Administer a second threshold test at an interval of two to six weeks, to those children who fail the first threshold test.

8. See "Manual for School Audiometrist" for Threshold Procedure.

C. REFERRAL CRITERIA

A child is considered to have "failed" the threshold test and is referred for a medical/ audiological examination if either or both of the following criteria are met:

1. A hearing level of 30 decibels or greater for two or more frequencies in the ear at, 500, 1000, 2000, and 4000 Hz, or a hearing level of 40 decibels or greater for any one of the frequencies tested, 500 through 4000 Hz, on two threshold tests completed at an interval of at least two weeks and no more than six weeks; or

2. There is evidence of pathology, e.g., an infection of the outer ear, chronic drainage or a chronic earache.

D. RECORDING

1. Transfer all results to health record of each child. Indicate on health record when a referral was made and follow-up. Notation should be made on the health record of the hearing status of each child who is referred for medical evaluation.

2. Complete LEA Medi-Cal billing forms. Copies need to be stored in health office for 3 years.

3. Each school shall prepare an annual report of the school hearing program using "*Annual Report of Hearing Testing"* forms (PM 100). Form is provided by the State Department of Health Services with copies to the District Superintendent and the County Superintendent of Schools.

4. The nurse will inform classroom teacher of all hearing problems identified, encourage possible adjustments in the school program, and will document this discussion in the health record.

For reference: http://www.dhcs.ca.gov/services/hcp/Documents/audmanschool.pdf

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

HEARING & VISION HEALTH INVENTORY WORKSHEET

Student's Name	ID#/DOB	Grade	Room #	Vision R	L	Recheck R	L	Hearing R	L	THRESHOLDS 1st Test Normal	Retest	Final Test Normal	Follow-up Needed	New Case	Old Case	Parent Notified	Under Treatment	Referrals/Comments

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

HEARING THRESHOLD TEST

Student_____ID#_____DOB_____Grade____

School_____Teacher_____Nurse _____

Threshold #1 Date_____ Threshold #2 Date _____

L		R	L		R
_____	500	_____	_____	500	_____
_____	1000	_____	_____	1000	_____
_____	2000	_____	_____	2000	_____
_____	4000	_____	_____	4000	_____

PASS REFER

(Circle One)

Known Problems _____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

HEARING THRESHOLD TEST

Student_____ID#_____DOB_____Grade____

School_____Teacher_____Nurse _____

Threshold #1 Date_____ Threshold #2 Date _____

L		R	L		R
_____	500	_____	_____	500	_____
_____	1000	_____	_____	1000	_____
_____	2000	_____	_____	2000	_____
_____	4000	_____	_____	4000	_____

PASS REFER

(Circle One)

Known Problems _____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

REPORT OF HEARING SCREENING

TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER

School_____ Date _____

Student_____ ID#_____ Grade/Teacher_____ DOB _____

Dear Parent/Guardian:

Your son/daughter did not pass a hearing test given on _____

We urge you to give this prompt attention. Please consult with your health care provider for an examination and recommendation regarding your child's hearing problem. A report of our findings may be helpful to the provider and is below. THIS IS A SECOND TEST.

	500 Hz	1000 Hz	2000 Hz	4000 Hz
School Findings R				
L				

If you need help locating a health care provider or require financial assistance, contact your school nurse.
School Nurse_____ Telephone _____

PLEASE DON'T WRITE BELOW THIS LINE

RETURN TO SCHOOL NURSE

RESULTS OF PROVIDER'S EXAMINATION DATE OF EXAM _____

	500 Hz	1000 Hz	2000 Hz	4000 Hz
Provider's Findings R				
L				

DIAGNOSIS _____

RECOMMENDATIONS FOR SCHOOL _____

Child's Name: _____

Provider's Signature _____

Provider's Name (Print) _____

Provider's Address _____

Telephone _____

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

REPORTE DE OBSERVACION DEL OIDO

POR FAVOR LLEVE ESTA FORMA A SU MEDICO

Escuela_____ Maestro_____ Grado_____ Fecha _____

Alumno_____ ID#_____ Fecha de Nacimiento _____

Estimados Padres/Tutores:

Su hijo/a no pasó la prueba del oído que se le dió el _____

Le pedimos su atención inmediata. Por favor consulte con su médico para que le haga un examen y para que le dé una recomendación acerca del problema del oído de su niño. Puede ser que le ayude a su médico un reporte de nuestros descubrimientos y lo incluímos abajo. ESTE ES EL SEGUNDO EXAMEN

		500 Hz	1000 Hz	2000 Hz	4000 Hz
Resultados de la Escuela	**R**				
	L				

Si necesita ayuda para encontrar ayuda médica o ayuda financiera, por favor comuníquese con la enfermera de la escuela.
Enfermera de la Escuela_____ Teléfono _____

NO ESCRIBA DEBAJO DE ESTA LINEA
RETURN TO SCHOOL NURSE

RESULTS OF PROVIDER'S EXAMINATION DATE OF EXAM _____

		500 Hz	1000 Hz	2000 Hz	4000 Hz
Provider's Findings	**R**				
	L				

DIAGNOSIS _____

RECOMMENDATIONS FOR SCHOOL _____

_____

_____

Child's Name: _____

Physician's Signature _____

Physician's Name (Print)_____ Telephone _____

Physician Address _____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SECOND NOTICE HEARING REFERRAL

School_____ Date _____

Dear Parent/Guardian:

Earlier this year we notified you that_____ did not pass a hearing test. We need to know if this student has received a medical evaluation. Please complete the following and return it to school before_____.

☐ A MEDICAL EVALUATION HAS BEEN DONE. WE WILL ASK THE HEALTH CARE PROVIDER TO SEND A REPORT FOR THE SCHOOL.

☐ THIS IS A PERMANENT LOSS. WE WILL PROVIDE A MEDICAL REPORT TO THE SCHOOL.

☐ WE HAVE AN APPOINTMENT SCHEDULED TO EVALUATE THE PROBLEM.
Date _____

☐ OTHER_____

_____

_____

_____

Thank you,

_____
School Nurse Telephone

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

SEGUNDO AVISO DE LA RECOMENDACION PARA EXAMEN DEL OIDO

Escuela_____ Fecha _____

Estimado Padre/Tutor:

En los principios de este año les avisamos que_____ no había pasado el examen del oído. Necesitamos saber si su hijo/a ha recibido una evaluación médica. Por favor complete la forma siguiente y regrésela a la escuela antes del_____.

D SE HA HECHO UNA EVALUACION MÉDICA. LE PEDIREMOS AL MÉDICO QUE ENVIE UN REPORTE A LA ESCUELA.

D HA PERDIDO PERMANENTEMENTE EL OIDO. DAREMOS UN REPORTE MÉDICO A LA ESCUELA.

D TENEMOS UNA CITA PARA EVALUAR EL PROBLEMA. Fecha _____

D OTRO_____

_____

_____

Gracias,

_____
Enfermera de la Escuela No. de Teléfono

HEARING REFERRAL LIST

HEAR CENTER
301 East Del Mar Boulevard Pasadena, CA 91101
(626) 796-2016 (Voice)
(626) 796-2320 (Fax)
Website: www.hearcenter.org E-mail: info@hearcenter.org
The HEAR Center was founded in 1954 to reduce the effects of deafness by early identification. They provide comprehensive audiological services (diagnostic hearing testing, comprehensive evaluations for hearing aid amplification, guidance in aural rehabilitation and the conservation of hearing) to children and adults and speech/language pathology services to children between ages 1 to 10 years.

HOUSE RESEARCH INSTITUTE (HRI)
2100 West 3 rd Street Los Angeles, CA 90057
(800) 388-8612 (Voice-Toll Free)
(213) 483-4431 (Voice)
(213) 484-2642 (TTY/TDD) (213) 483-8789
(Fax) Website: www.hei.org E-mail: info@hei.org
The HRI is an organization dedicated to advancing hearing science through research and education to improve quality of life. They are also working to improve hearing aids and auditory implants, diagnostics, clinical treatments and intervention methods. Children's services are conducted through the Care Center Clinical Services Department. Services provided include: outpatient infant screening, diagnostic audiology, auditory rehabilitation, developmental psychological exams which determine eligibility for cochlear implants, speech and language evaluation and therapy and cochlear implant services.

YOUNG AND HEALTHY
37 N. Holliston Ave.
Pasadena, CA 91106
(626) 795-5166
M-F 7:30-3:30 pm

PRIVATE PHYSICIANS

Charles Battaglia, M.D. ENT
547 East Union St., Pasadena, CA 91101
Phone: 626-796-6164
Fax: 626-796-0883

Dr. Battaglia sees and treats all aspects of general otolaryngology including head and neck disease, both benign and cancerous, sinus disease, nasal congestion and obstruction, ear pain, hearing loss, nose bleeds, tonsillitis, hoarseness, dizziness, salivary gland disease, voice disorders, thyroid disorders, sleep apnea and ear infections. He treats children and adults of all ages.

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

TEACHER'S REFERRAL FOR A HEARING TEST

REFERRAL FOR HEARING TEST: School: _____

_____ is referred for a hearing test for the following reasons:
Child's Name

Please Check

_____ 1. Substitution of sounds, such as t for k; s for z; k for sk; and ts for s.
_____ 2. Omission of sounds - chiefly final consonants.
_____ 3. Careless and inaccurate production of all sounds.
_____ 4. Abnormally high-pitched voice.
_____ 5. Very soft voice.
_____ 6. Dull, monotonous voice.
_____ 7. Harsh, rasping or metallic voice.
_____ 8. Turning the head to catch sounds with the better ear.
_____ 9. Frowning constantly.
_____ 10. Straining or leaning forward to hear speaker.
_____ 11. Eyes constantly in lips of speaker rather than looking at eyes.
_____ 12. Cupping an ear to listen.
_____ 13. Lacks interest in any activity which requires hearing ability.
_____ 14. Listlessness, frequent inattention.
_____ 15. Abnormally disturbed by loud noises.
_____ 16. Mouth breathing.
_____ 17. Severe illness or head injury since hearing was last tested.
_____ 18. Draining ear.
_____ 19. Extreme fatigue early in the day.
_____ 20. Severe and continued respiratory infections.
_____ 21. Earache (may notice cotton in ear)
_____ 22. Lack of confidence.
_____ 23. Extreme antisocial behavior.
_____ 24. Extreme introversion.
_____ 25. Frequent nervousness and irritation over minor details.
_____ 26. Two or three behind age level in school.

Date_____ Referred by _____
Principal, teacher, parent, speech therapist,
psychologist, nurse (please underline)

State of California-Health and Human Services Agency

Department of Health Care Services
Systems of Care Division

ANNUAL REPORT OF HEARING TESTING

Reporting School Year

REPORT DUE JUNE 30
CURRENT SCHOOL YEAR

CDS Code Number (County / District)	School District	County

Address (number and street)	City	ZIP Code	Office Telephone Number

Supervisor of Health Name: Title:	Email Address

GRADES IN DISTRICT (1)	Enter Number of Pupils Enrolled in EACH GRADE as of the October (CALPADS) Report (2)	INITIAL SCREENING: Number of Pupils Screened Per Sec. 2951(c), CCR, Title 17 (3)	RESULTS: Number of Pupils Failed Both Threshold Tests Per Sec. 2951(d), CCR, Title 17 (4)	DISPOSITION AND FOLLOW-UP: Number of Pupils Referred for Medical and/or Audiological Evaluation [From Col. (4)] (5)	DISPOSITION AND FOLLOW-UP: Number of Pupils Examined by Doctor and/or Audiologist or Under Treatment (6)
K					
* or ----------					
1					
2					
3					
4					
*5					
6					
7					
*8					
9					
10					
* or ----------					
11					
12					

* All pupils in these grades shall be tested annually (Section 2951(c), CCR, Title 17).

SPECIAL EDUCATION: (See instructions on reverse side of this form.)

DISTRIBUTE A COPY BY ONE OF THE FOLLOWING:

❑ Mail to:
California Department of Health Care Services
Systems of Care Division
Hearing Conservation Program
MS 8103
P.O. Box 997413
Sacramento, CA 95899-7413
Attention: Health Program Specialist

❑ Fax: (916) 327-1106 OR
Email:
HearingConservationProgram
@dhcs.ca.gov

TESTING CONDUCTED

❑ District School Nurse–Audiometrist, per Section 49420, CEC and Section 2950, CCR, Title 17.
❑ District School Audiometrist, per Section 44879, CEC.
■ District Speech/Hearing Specialist, per Section 49454, CEC.

Testing was conducted by a private agency/individual authorized by the county superintendent, per Section 49452, CEC:

SEE OTHER SIDE FOR INSTRUCTIONS.

INSTRUCTIONS FOR COMPLETING FORM PM 100
ANNUAL REPORT OF HEARING TESTING

A. Complete identifying information. Insert reporting school year. Your District's "CDS CODE NUMBER" can be obtained from the California Public School Directory; it designates your COUNTY and DISTRICT, i.e., 19-64212 is the Code Number for the ABC Unified Schools in Los Angeles County. The PERIOD COVERED will include the date the hearing testing was started and the date when *testing and follow-up* were completed.

B. COLUMN (1). **GRADES IN DISTRICT:** Please *check* box for the highest grade in your District.

COLUMN (2). **Number of Pupils ENROLLED in Each Grade:** Enter the number of pupils enrolled in *ALL GRADES* as of the October (R-30) report made to the California Department of Education.

COLUMN (3). **INITIAL SCREENING: Number of Pupils SCREENED:** Enter the number of pupils in each grade that were *screened* per Section 2951(c), California Code of Regulations (CCR), Title 17. (Figures for tests conducted in all grades SHALL be included.)

COLUMN (4). **Number of Pupils who FAILED BOTH THRESHOLD TESTS:** Enter number of pupils who failed BOTH THRESHOLD TESTS per Section 2951(d), CCR, Title 17.

COLUMN (5). **Number of Pupils REFERRED for Medical and/or Audiological Evaluation:** From column number (4), enter the number of pupils who were referred per Section 2951(d), CCR, Title 17.

COLUMN (6). **Number of Pupils EXAMINED by Doctor and/or Audiologist or Under Treatment:** From column number (5), enter the number of pupils who reached the doctor and/or audiologist, were examined, or who are known to be receiving treatment.

C. **SPECIAL EDUCATION:** Briefly describe the audiometric, audiological, and medical services used when evaluating and placing pupils in need of special education. (You may attach additional information if necessary.)

D Check the appropriate boxes describing testing personnel. *If any of the testing services were Provided by contract with an authorized agency,* per CEC, Section 49452, *enter the name of the agency, organization, or company.* A county office of education and the county health department are considered to be "authorized agencies."

E. Check the distribution and send copies of the report as indicated.

THIS REPORT IS DUE ON OR BEFORE JUNE 30 OF THE CURRENT SCHOOL YEAR

VISION SCREENING GUIDELINES

VISION (C.E.C. 49455)

"Upon first enrollment in a California school district of a child at a California elementary school, and at least every third year thereafter until the child has completed the 8th grade, the child's vision shall be appraised by the school nurse. This evaluation shall include tests for acuity and color vision; however, color vision shall be appraised once and only on male children and the results shall be entered on the health record of the pupil."

1. All Individual vision tests are given to:

    a. All pupils who are:

        1. New to the district
        2. Enrolled in special education class or program
        3. Referred by the classroom teacher

    b. Pupils in grades kindergarten, 2, 5, 8 and 10

        1. Grades K, far point, cover and convergence.
        2. Grades 2, 5, 8 – near and far point
        3. First Grade (boys only) - color vision using pseudo-isochromatic plates

Retesting

All students who fail initial screening must be rescreened.

Referrals

1. The school nurse shall provide the parents or guardians of children who fail the second vision screening with written notification of the test results. Criteria for test failure are:

    a. A visual acuity of 20/50 or worse for children under six years of age. The designation of 20/50 or worse indicates the inability to identify accurately the majority of letters or symbols on the 40-foot line of the test chart at a distance of 20 feet or on the 20-foot line of the test chart at a distance of 10 feet.

    b. A visual acuity of 20/40 or worse for children six years of age or older. This means the inability to identify the majority of letters or symbols on the 30-foot line of the test chart at a distance of 20 feet or on the 15-foot line of the chart at a distance of 10 feet.

    c. A difference of visual acuity between the two eyes, for children of all ages, for two lines or more on the optotype chart; for example, visual acuity of 20/20 in one eye and 20/40 in the other or 20/30 in one eye and 20/50 in the other eye.

d. A manifestation of significant signs or symptoms (through a student's behavior, complaints, appearance, performance, or physical activity) that suggest a visual difficulty

2. Parents of children who are active and wear glasses should be encouraged to have prescription ground safety lenses to avoid eye injury in case of accident.

3. To qualify for referral and enrollment in a class for partially sighted, a disability equal to or greater than the following should exist.

   a. Those children who have visual acuity of between 20/70 and 20/400 in the better eye after correction.

   b. In addition, those children recommended by an ophthalmologist because of progressive conditions or for temporary special conditions following an illness which has affected the eyes, or during a period of ocular treatment, such as the occlusion of one eye for strabismus.

Recording

1. Dates and results of all screening and referrals should be recorded on each pupil's health record.

2. Notification should be made on the health record of the vision status of each child who is referred for medical evaluation.

3. The classroom teacher should be informed of all vision problems identified among her pupils and documented in the health record. Possible adjustments in the school program should be discussed.

An annual report of vision and hearing testing must be completed in June.

Vision Screening Procedures

Distance Vision

1. Position the student 10 or 20 feet from the appropriate chart, depending on the chart used. The student's eyes must be parallel to and directly above the line.
2. Have older students cover the left eye with an occluder. Proceed to test the right eye. Then reverse the procedure and test the left eye.
3. For younger students, it is recommended that an occlusive, adhesive eye patch be used.
4. Tell the student to keep both eyes open during the test.
5. Make sure the occluder or occlusive eye patch does not press on the eye.
6. The occluder must completely cover the eye, and the observer must watch the pupil to make certain he or she is not cheating.
7. Use a fresh cup, occluder, or "pirate patch" for each student to prevent the spread of any infectious condition from one student to another, or clean the plastic occluder with a solution of 70 percent isopropyl alcohol after each use.
8. Tell students who wear glasses to keep the glasses on, unless they say that vision is better without glasses or that the glasses are to be worn only for reading. Then test that student first with glasses on and then without glasses.
9. Test the right eye first, then the left eye, and then both. A standardized routine avoids confusion and facilitates recording. Observe the student for squinting, forward leaning, or turning the head during testing.
10. Begin testing with the 20-/40-foot line and proceed with testing through the 10-/20-foot line. Testing beyond the 10-/20-foot line is not necessary.
11. Begin testing younger students by using larger letters for training and then move to threshold letters.
12. Use the Illiterate "E" Chart (or other age-appropriate tests) for preliterate students or those with special needs who are unable to read the optotype letters. When using the "E" chart, follow these guidelines:
    - Indicate, by hand, which way the "E" points. Oral responses may be agreed upon.
    - Avoid fatigue by having the student start reading the equivalent of the 50-foot line if no vision difficulty is suspected.
    - Check the student's performance on the equivalent of the 20-foot line if the student responded readily and correctly to the 50-foot line.
    - Move promptly from one symbol or one line to another. Encourage the student to do his or her best to read symbols. Suggest guessing when the student falters. If strain is apparent, do not pressure the student for responses.
    - Make appropriate adjustments if the student is unable to read the 100/200 symbols. Move the student forward 5 or 10 feet as necessary. Use the new distance as the numerator in the notation; for example, 15/100, or 10/100, or even 5/100 (distance/foot letter size).
    - Follow the same procedure as that used to test older children with the alphabet chart.

Near Vision:

NEAR VISUAL ACUITY CARDS

1. Prepare the testing area, making sure that it is as quiet as possible and free from distraction. Be sure that the lighting is adequate and that the near cards are sufficiently illuminated for easy viewing.

2. Instruct the student to keep glasses or contact lenses on for testing. Exceptions: Glasses for DISTANCE ONLY should be worn for FAR test only. Glasses for READING ONLY should be worn for NEAR test only.

3. Occlude the left eye and test the right eye first.

4. Have the student hold the near card at the distance specified in the manufacturer's instructions

(approximately 13-16 in, [33-40 cm]) and ask the student to identify the smallest letter(s)/symbol(s) possible.

5. Record Near visual acuities similar to the method used for Far visual acuities. Follow the appropriate scoring protocol for the HOTV letter and LEA symbol tests of Near Visual Acuity.

6. Switch occluder to the right eye and repeat the Near Visual Acuity test on the left eye.

Referral Criteria:

1. Any student enrolled in Kindergarten and Grade 1 whose visual acuity in either eye is less than 20/40 or if a two line difference exists between the eyes (ie. 20/25 and 20/40) should be re-tested. If re-testing results in visual acuity less than 20/40 in either eye or a two line difference between the eyes, referral is indicated. Any student in Grade 2 or above whose visual acuity in either eye is less than 20/30 or if a two line difference exists between the eyes (ie. 20/25 and 20/40) should be re-tested. If re-testing results in visual acuity less than 20/30 in either eye or a two line difference between the eyes, referral is indicated.

2. Unless the student is showing signs of impending illness, re-testing should be scheduled without undue delay.

3. The results should be recorded on the student's health record in the appropriate space, giving the date, name of test, the fractional reading for each eye and "passed" or "failed".

Color Vision

- Use approved color vision book, i.e., Ishihara.
- Have student use paint brush to follow pattern on book if necessary.
- Need **good** light source outside or inside; fluorescent lamp not recommended. Don't use bright room light that will reflect bright colors on walls.
- Follow manufacturer's directions for administration and interpretation, i.e., red-green color deficiency. Good idea to test all siblings of known color deficient child.
- Notify parent, teachers, counselor. If student does not pass, use term of "color deficiency", not "color blindness" to describe problem.

External Observation

Examine thoroughly Recommend: E.O.M.'s
Have child follow penlight (NOT LIT) or pencil eraser. Muscle Balance

Light reflex. Shine light from direct center into child's eyes with child looking straight ahead. Image should reflect on exact same place in both eyes.

Cover and Convergence Test

Have child fixate at an object in the distance. Put occluder over one eye. Hold for a few seconds, then quickly remove cover. If covered eye is observed to "jump" back into place, strabismus is presumed. Repeat with opposite eye. Normally, eyes remain still when covered.

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

<u>HEARING & VISION HEALTH INVENTORY WORKSHEET</u>

Student's Name	ID#/DOB	Grade	Room #	Vision R	L	Recheck R	L	Hearing R	L	THRESHOLDS 1st Test Normal	Retest	Final Test Normal	Follow-up Needed	New Case	Old Case	Parent Notified	Under Treatment	Referrals/Comments

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

TEACHER'S REFERRAL FOR A VISION TEST

Student's name _____ DOB _____

Grade/Teacher _____ Date _____
(Circle observations)

APPEARANCE

1. Encrusted or swollen eyelids.
2. Watery or red eyes.
3. Recurring sties.
4. Crossed eyes.
5. Sensitivity to light.

BEHAVIOR AND COMPLAINTS

1. Rubs eyes frequently; attempts to brush away blur.
2. Dizziness, headaches or nausea following class work.
3. Inattentive to chalkboard or wall chart lessons.
4. Complains of itchy, burning or scratchy eyes.
5. When looking at distant objects:
    a. holds body tense
    b. contorts face in attempt to see clearly
    c. thrusts face forward
    d. squints eyes excessively
    e. uninterested in distant objects
6. When reading or looking at close objects:
    a. blinks repeatedly
    b. holds book too close or too far from face
    c. makes frequent changes in distance at which book is held
    d. inattentive during lesson
    e. stops working after a short period
    f. shuts or covers one eye
    g. tilts head to one side
    h. tends to reverse words or syllables
    i. tends to lose place on page
7. Other: _____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

REPORT OF VISION SCREENING

School _____ Date _____

Student _____ DOB _____

Grade/Teacher _____ Dear Parent/Guardian:

As a result of a recent vision screening program at school, we believe that your child should have a complete eye examination. We urge you to give this your prompt attention. Please take this form to your eye examiner and ask him to complete it and return it to the school. If you need help locating a health care provider or require financial assistance, contact your school nurse.

Nurse _____ Principal _____

NOTE TO EXAMINER: Complete examination was suggested to the parents because of:

Performance on Snellen Test	R.20/	L.20/
Near Vision Test	R. 20/	L. 20/

Signs and Symptoms _____

_____

The school will appreciate a report from you and any recommendation you desire to make. This information will be of help in planning the educational program for this child. Thank You.

REPORT OF EXAMINER TO THE SCHOOL

VISUAL ACTIVITY

Without lenses		With lenses	
R.20/	L.20/	R.20/	L.20/
Both 20/		Both 20/	

GLASSES

_____ Not prescribed
_____ Prescribed
_____ To be worn all the time
_____ To be worn for close work only
_____ To be worn for distance only
_____ Safety lenses

Diagnosis:
Preferential seating recommended _____
Special materials that would be helpful _____
Other recommendations or suggestions _____
Date patient should return further examination _____

Signature _____ Date _____

Address _____

NOTE TO EXAMINER: Please mail completed form to: (Stamp school address here)

PASADENA UNIFIED SCHOOL DISTRICT
PROGRAMAS DE SALUD

REPORTE DE INFORMACION DE UN EXAMEN DE LA VISTA

Escuela _____ Fecha _____

Alumno _____ Fecha de nacimiento _____

Grado/Profesor _____ Estim ado

Padre/Tutor:

Como resultado de un programa reciente de examenes de la vista en la escuela, creemos que su nino/a debe de tener un examen completo de la vista. Le pedimos que de su pronta atencion a este asunto. Por favor lleve esta forma a quien le examine la vista y pidale que la complete y la regrese a la escuela. Si desea mas informacion, la enfermera de la escuela puede ayudarle.

Enfermera _____ Director/a _____

NOTE TO EXAMINER: Complete examination was suggested to the parents because of:

Performance on Snellen Test	R.20/	L.20/
Near Vision Test	R. 20/	L. 20/

Signs and Symptoms _____

_____

The school will appreciate a report from you and any recommendation you desire to make. This information will be of help in planning the educational program for this child. Thank You.

REPORT OF EXAMINER TO THE SCHOOL

VISUAL ACTIVITY

Without lenses		With lenses	
R.20/	L.20/	R.20/	L.20/
Both 20/		Both 20/ only	

GLASSES

_____ Not prescribed
_____ Prescribed
_____ To be worn all the time
_____ To be worn for close work
_____ To be worn for distance only
_____ Safety lenses

Diagnosis:
Preferential seating recommended _____
Special materials that would be helpful _____
Other recommendations or suggestions _____
Date patient should return further examination _____

Signature _____ Date _____

Address _____

NOTE TO EXAMINER: Please mail completed form to: (Stamp school address here)

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

REPORT OF A COLOR VISION TEST

School _____ Date _____

Student _____ ID# _____ DOB _____

Grade/Teacher _____

Dear Parent/Guardian:

As a result of a recent screening program for color vision, your child appears to have a deficiency in color discrimination. If you desire additional information, the school nurse will be glad to discuss these findings with you.

School Nurse _____ Phone # _____

The nurse is at school on days circled: Mo Tu Wd Th Fr

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

REPORT OF A COLOR VISION TEST

School _____ Date _____

Student _____ ID# _____ DOB _____

Grade/Teacher _____

Dear Parent/Guardian:

As a result of a recent screening program for color vision, your child appears to have a deficiency in color discrimination. If you desire additional information, the school nurse will be glad to discuss these findings with you.

School Nurse _____ Phone # _____

The nurse is at school on days circled: Mo Tu Wd Th Fr

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

REPORTE DE UNA PRUEBA DE VISION DE COLOR

Alumno/a_____ Fecha _____

Escuela_____ Telefono _____

Estimados Padres

Como resultado de un programa de observacion para la vision de color, parece que su nino/a tiene una deficiencia en discriminacion de colores. Si Uds. desean mas informacion, la enfermera escolar estara dispuesta en discutir estos hallazgos con Uds.

Enfermera de la Escuela_____ Teléfono _____
La enfermera escolar se encuentra disponible en los dias circulados: Lu Ma Mi Ju Vi

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

REPORTE DE UNA PRUEBA DE VISION DE COLOR

Alumno/a_____ Fecha _____

Escuela_____ Telefono _____

Estimados Padres

Como resultado de un programa de observacion para la vision de color, parece que su nino/a tiene una deficiencia en discriminacion de colores. Si Uds. desean mas informacion, la enfermera escolar estara dispuesta en discutir estos hallazgos con Uds.

Enfermera de la Escuela_____ Teléfono _____
La enfermera escolar se encuentra disponible en los dias circulados: Lu Ma Mi Ju Vi

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

REQUEST FOR VISION/GLASSES INFORMATION FROM PARENT

Student _____ DOB _____

Grade/Teacher _____

To: The Parents/Guardian

Your child's teacher tells me that he/she is not wearing glasses, although the Health Record indicates that:

- ☐ A referral for an eye exam was sent home
- ☐ He/she has worn glasses in the past.

Please check below to indicate why the glasses are not being worn and have your child return this form to me tomorrow.

- ☐ Glasses are no longer needed.
- ☐ Glasses are broken and are being repaired.
- ☐ Glasses are lost and are being replaced.
- ☐ My child has not yet had his/her eyes examined.
  We will see the doctor on _____
  (date)

Comments: _____

_____

Please call me if you need assistance obtaining new glasses. Thank you for your prompt attention to this matter.

_____ _____ _____
School Nurse Date Phone #

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

PETICION PARA INFORMACION DE LOS PADRES DE VISION/LENTES

Alumno_____Fecha de Nacimiento _____

Grado/Maestro _____

Para: Los Padres/Tutores:

El maestro de su niño me dice que no está usando lentes, aunque el Récord de Salud indica que:

☐ Se envió a casa una referencia para el examen de la vista.

☐ Ha usado lentes en el pasado.

Por favor marque abajo para indicar por qué el niño no usa los lentes y envíeme esta forma mañana con su niño.

☐ Se quebraron los lentes y se están reparando.

☐ Se perdieron los lentes y se están reponiendo.

☐ Todavía no le han hecho el examen de la vista a mi niño.
Tenemos cita con el médico el _____
(fecha)

Comentarios:

_____

_____

Por favor llámeme si desea ayuda para obtener lentes nuevos. Gracias por su pronta atención a este asunto.

_____ _____ _____
Enfermera de la Escuela Fecha No. de Teléfono

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

VISION REFERRALS

Agencies

Young and Healthy
www.yh**pasadena**.org
Offers free vision exams and glasses for uninsured students
(626) 795-5166

Foothill Unity Center, Inc.
(626)358-3486
www.foothillunitycenter.org
415 W Chestnut Ave., Monrovia, CA 91016
Offers case management, transportation, referrals and access to medical, dental, vision and mental health care for low income, homeless or uninsured clients.

Optometrists:

Linden Optometry
477 E. Colorado Blvd.
Pasadena, CA 91101
(626)792-1193
Accepts Medi-Cal

Vision One
709 East Colorado Blvd., Suite 101
Pasadena, CA 91101
(626) 795-3453
Accepts Medi-Cal

Dr. Charles Korth
1 W. California Blvd., Suite 513
Pasadena, CA 91105
(626) 793-9987
No Medi-Cal

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

ANNUAL REPORT OF VISION TESTING

School Name	Superintendent		
Number and Street	City	Zip Code	County
Period covered	Prepared by	Telephone ( ) -	

RESULTS OF SCREENING
(Include pupils in gifted and remedial speech classes in regular grades)

Grade level	Enrollment in each grade screened	Total number of pupils screened	Number of pupils rescreened	Number of pupils referred for professional examination	Number of pupils referred actually under professional care	Color vision (boys)	
						Number tested	Number failed
K	1	2	3	4	5		
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
Sp. Ed.							
Totals							

SCOLIOSIS SCREENING GUIDELINES

State law (C.E.C. 49452.5) requires that all school districts in California provide scoliosis screening at the junior high school. School nurses conduct this screening and necessary re-screenings during regular P.E. classes. The mandated grade levels are 7th grade females and 8th grade males.

Scoliosis is a side-to-side curvature of the spine. Each student is observed by a school nurse from the front, back, and side. The uncovered spine is examined for any uneven shapes. If there are unusual findings, parents are notified in writing and the student is referred for medical evaluation and diagnosis.

Frequent signs are a prominent shoulder blade, uneven hip or shoulder levels, unequal distance between arms and body and clothes that do not "hang" correctly.

The rationale for screening during early adolescence is that the body is still growing. The student's muscles and skeleton respond to treatment with maximum recovery possible. Screening during early adolescence can prevent adult disability. Eighty percent of scoliosis tends to run in families and affects more girls than boys.

PROCEDURES FOR SCREENING

1. Schedule date with screening team facilitator and school master calendar.

2. Send parent scoliosis information letters home with all 7th grade females and 8th grade males.

3. Communicate with P.E. teachers; screenings need to be conducted with students in their P.E. clothes.

4. Order computer printouts of 7th grade females and 8th grade males from the district data processing clerk.

5. Screening team nurses are to arrange P.E. office or locker room for screenings.

6. Speak with P.E. staff in advance; P.E. teachers usually escort students in and out of screening areas.

PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER • HEALTH PROGRAMS

SCOLIOSIS SCREENING

Date:_____

Dear Parents/Guardians:

Scoliosis screening is mandated under the Education Code (Section 49452.5) on all 7th grade girls and all 8th grade boys. The school nurse will conduct the screening this semester.

Scoliosis is a sideways curvature of the spine, most commonly detected in children from 10-14 years of age. For some reason not yet known, scoliosis is about eight times more common in girls than boys. It is estimated that 1 out of every 100 girls between the ages of 10-14 have scoliosis, but it usually goes undetected until later years. If this condition is diagnosed in the very beginning stages, corrective treatment is usually successful. Discovery and treatment while the spine growing will, in most cases, prevent the curve from becoming worse.

If the nurse suspects symptoms of scoliosis, she will contact you and explain what action you need to take.

We would appreciate it if your child would wear a blouse or tee shirt which can be lifted easily, since a thorough look at the back is necessary. If you have any questions, please call your school nurse.

If you do not want your child to participate in this program, please write your school nurse immediately.

Sincerelv.

Ann Rector
Director of Health Programs

APPROVED:

Brian McDonald
Superintendent

351 South H udson Ave. Rm 126 ·Pasadena, CA 91109
(626) 396-3600 Ext. 88240 ·Fax (626) 584-1540
www.pusd.us

PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER , HEALTH PROGRAMS

EXAMEN DE ESCOLIOSIS

Fecha:_____

Estimados Padres/Tutores:

El examen de la escoliosis se da por mandato del Codigo de Educacion (Seccion 49452.5) a todas las nifias del 7 grado y a todos los nifios del 8 grado. La enfermera de la escuela darii el examen este mes.

Escoliosis es la curvatura lateral de la columna vertebral, que comunmente se encuentra en ninos de I0-14 afios de edad. Por alguna razon que todavia no se sabe, escoliosis es aproximadamente 8 veces mas comun en las ninas que en los ninos. Se estima que I de cada cien ninas de I0-14 afios tienen escoliosis, pero usualmente no se encuentra hasta miis tarde. Si esta condicion se diagonistica en sus principios, el tratamiento corrective por lo general tiene exito. El descubrir y tratar la escoliosis mientras que la columna vertebral todavia estii creciendo puede, en la mayor parte de los casos, prevenir que la curvature se empeore.

Si la enfermera sospecha sintomas de escoliosis, ella se pondrii en contacto con ustedes y Jes explicarii la accion que deben tomar.

Les agradecemos si su hijo/a usa una blusa o camiseta "T", la cual se pueda quitar fiicilmente, ya que se le tiene que revisar la espalda completamente. Si tienen alguna·pregunta, por favor llamen a la enfermera de su escuela.

Si no desean que su nino/a participe en este examen, por favor escriban inmediatamente a la enfermera de su escuela.

Atentamente.

Ann Rector
Director of Health Programs

APROBADO:

Brian McDonald
Superintendent

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PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

REFERRAL FOR MEDICAL EVALUATION - SCOLIOSIS

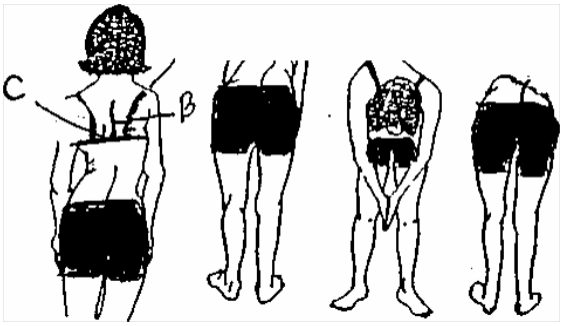
Student_____ ID#_____ DOB_____ Grd/Teacher_____

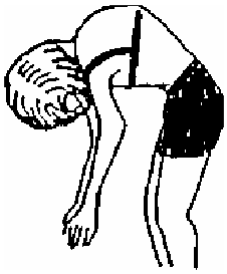
School_____ Nurse_____ Date _____

Dear Parent/Guardian:

A scoliosis screening program was recently conducted at school to detect possible spinal problems. Your child was screened by the school nurse and it is recommended that he/she be further examined by your health care provider to correctly establish if a problem exists. Please take this form with you at the time of the doctor's examination. If you have any questions, please contact your school nurse.

NOTE TO EXAMINER: The following observations were made during school screening:





___Shoulder higher	Rt.	Lt.
___Obvious spinal curvature	Rt.	Lt.
___Prominent shoulder blade	Rt.	Lt.
___Elevated shoulder blade	Rt.	Lt.
___One hip higher	Rt.	Lt.
___Arm to body space greater	Rt.	Lt.
___Waist crease uneven	Rt.	Lt.
___Thoracic prominence (elevation)	Rt.	Lt.
___Lumbar prominence (elevation)	Rt.	Lt.
___Kyphosis (round back)	Rt.	Lt.
___Lordosis (sway back)	Rt.	Lt.

EXAMINER'S REPORT TO THE SCHOOL

Examination Results:

___ No significant findings at this time
___ Standing (anterior-posterior) x-ray shows: _____
Need for further evaluation on _____
___ Treatment recommended: _____

Please Print:

Examiner's Name_____ Signature _____

Date _____

Address_____ Phone _____

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

REFERENCIA PARA EVALUACION MÉDICA - ESCOLIOSIS

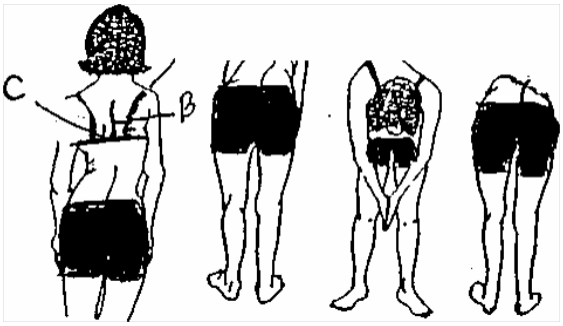
Alumno_____ ID#_____ Fecha de Nacimiento_____ Gr./Maestro _____

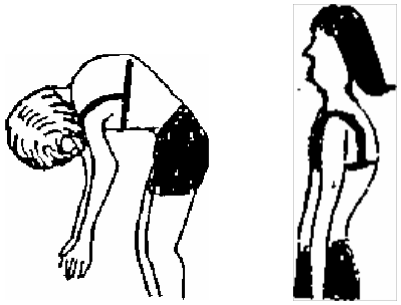
Escuela_____ Enfermera_____ Fecha _____

Estimado Padre/Tutor:

El programa de observación de la escoliosis se hizo recientemente en la escuela para ver si había posibles problemas de la espina dorsal. Su niño fue observado por una enfermera de la escuela y se está recomendando que su médico lo examine más detalladamente para establecer correctamente si tiene problemas. Por favor lleve esta forma cuando vaya a que le haga el examen el médico. Si tiene alguna pregunta, por favor comuníquese con la enfermera de la escuela.

NOTE TO EXAMINER: The following observations were made during school screening:





___Shoulder higher	Rt.	Lt.
___Obvious spinal curvature	Rt.	Lt.
___Prominent shoulder blade	Rt.	Lt.
___Elevated shoulder blade	Rt.	Lt.
___One hip higher	Rt.	Lt.
___Arm to body space greater	Rt.	Lt.
___Waist crease uneven	Rt.	Lt.
___Thoracic prominence (elevation)	Rt.	Lt.
___Lumbar prominence (elevation)	Rt.	Lt.
___Kyphosis (round back)	Rt.	Lt.
___Lordosis (sway back)	Rt.	Lt.

EXAMINER'S REPORT TO THE SCHOOL

Examination Results:

___ No significant findings at this time
___ Standing (anterior-posterior) x-ray shows: _____
Need for further evaluation on _____
___ Treatment recommended: _____

Please Print:

Examiner's Name_____ Signature _____

Date _____

Address_____ Phone _____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SCOLIOSIS REFERRAL LIST

1. CHILDREN'S HOSPITAL OF LOS ANGELES
   4650 Sunset Blvd
   Los Angeles, CA 90027
   (323) 669-2142 - Theresa
   $47.50 includes X-ray and MD evaluation in one appointment

2. ORTHOPEDIC HOSPITAL
   2400 S. Flower St.
   Los Angeles, CA 90007
   (213) 742-1300
   $40 Requires two visits

3. SHRINERS HOSPITAL
   3160 Geneva St
   Los Angeles, CA 90020
   (213) 368-3366
   Call for application - appointment to follow acceptance of application
   No Charge

4. PRIVATE PHYSICIAN

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SCOLIOSIS CLINIC APPOINTMENT

Name of Student_____ DOB _____

School_____ Grade _____

Dear Parent/Guardian:

A scoliosis screening program has been completed by the school nurses on 7th and 8th grade students.

A volunteer orthopedic physician will donate his time to examine those students who are referred to him by the school nurses.

The scoliosis clinic will be held on: _____
_____
_____
_____

Your child is being referred to this clinic and his/her appointment time will be on_____, at_____p.m.

If your child has not been seen by a medical doctor within the past year for this condition, you now have the opportunity of having him/her seen by the volunteer physician. ***A successful examination includes discussion between parent and doctor so it is essential that you attend.***

Please return the bottom portion of this form to the school nurse as soon as possible so that a definite appointment can be scheduled for you. If your child is currently under medical supervision, would you kindly write the name of the doctor or clinic on this page and return the form to us.

Thank You.

_____ _____
School Nurse Date

My Son/Daughter_____Grade _____

attending_____School, has my permission to see the volunteer physician for the scoliosis evaluation. I will be present for this examination.

_____ _____
Parent Telephone

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

CITA PARA LA CLINICA DE ESCOLIOSIS

Nombre del Estudiante_____ Fecha de Nacimiento _____

Escuela_____ Grado _____

Estimados Padres/Tutores:

Las enfermeras de la escuela han completado un programa para revisar la escoliosis de los alumnos del 7 y 8 grados.

Un médico ortopédico voluntario donará su tiempo para examinar a aquellos alumnos que las enfermeras le recomienden.

La clínica de escoliosis será el: _____
_____
_____
_____

Su ñino/a ha sido recomendado a esta clínica y la hora de su cita será el ,alas_____ p.m.

Si el médico no ha visto a su niño/a en el pasado año para esta condición, tienen la oportunidad de que lo vea el médico voluntario. ***Un buen examen incluye una discusión entre el padre/madre y el médico, asi que es esencial que asistan.***

Porfavor regresen la parte de abajo de esta forma a la enfermera de la escuela, tan pronto como sea posible, para hacer una cita definitiva. Si su niño está actualmente bajo supervisión médica, por favor escriba el nombre del médico o de la clínica en esta página y regresenos la forma.

Gracias.

_____ _____
Enfermera escolar Fecha

Mi hijo/a_____quien está en el_____grado, y quien asiste a la Escuela

_____, tiene mi permiso para que vea al médico voluntario, para la evaluación de la escoliosis. Estaré presente para el examen médico.

_____ _____
Padre/Tutor Numero de telefono

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SCOLIOSIS SCREENING HEALTH INVENTORY WORKSHEET

SCHOOL SITE _____ SCHOOL YEAR _____ SCHOOL DISTRICT _____

			Time Spent (Hours)								OTHER COSTS		Number of Pupils Screened							
DATE	EMPLOYEE TITLE	HOURLY RATE	PLANNING	TRAINING	SCREENING	RESCREENIG	REFERRING	NOTIFICATION	RECORDING	FOLLOW-UP	SUPPLIES/ POSTAGE	TRAVEL COSTS/TIME	NUMBER SCREENED		NUMBER RESCREENED		NUMBER REFERRED MEDICAL		NUMBER RECEIVED MEDICAL	
													GIRLS (7th)	BOYS (8th)	GIRLS (7th)	BOYS (8th)	GIRLS (7th)	BOYS (8th)	GIRLS (7TH)	BOYS (8TH)
TOTALS																				

I certify that the above is true and correct:

_____ _____
Signature Date

ANNUAL REPORT

SCOLIOSIS SCREENING (7-8)

(CHAPTER 1347/80 C.E.C. 49452.5)

In 1980, the legislature mandated that all female students in Grade 7 and all male students in Grade 8 be given a scoliosis screening; unless a parent or guardian refuses to consent to such a screening. This disfiguring spinal disease is generally observable and treatable in children in this age group.

POSITIONS/DEPARTMENTS GENERALLY INVOLVED

Middle School Nurses

UNIT COST RATE BASIS

Each district reimbursed based upon the number of seventh grade girls and eighth grade boys who are screened for scoliosis. A district need only prove compliance and number screened, not employee time spent.

Number screened x $ per student for follow-up = Total claimed amount.

REQUIRED DOCUMENTATION

- Listing of 7th grade girls screened
- Listing of 8th grade boys screened
- Number of parental notifications sent of intent to screen students
- The number of students who were rescreened
- The number of referrals made to medical care

ACTUAL COST COMPUTATION METHOD

Must prove unique circumstances and document costs and employee time spent.

ANNUAL REPORT

SCOLIOSIS SCREENING (7-8)

(CHAPTER 1347/80 C.E.C. 49452.5)

REIMBURSABLE ACTIVITIES

- **Examination of Student** and recording results on screening worksheets
- **Parental Notification** of intent to screen students
- **Administration of Program**

    - Planning and implementing screening
    - Training scoliosis screeners
    - Recording results on student health records

- **Follow-up Screening and Referral**

    - Rescreening students suspected of having scoliosis
    - Referring suspected cases to medical care
    - Following up on referrals to medical care

REQUIRED DOCUMENTATION

- Activity Log sheets for all employees whose time is being claimed
- Documentation as required under cost method listed above

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SCOLIOSIS SCREENING STATISTICS
School year _____

School Name _____ Nurse _____

1. Dates of screening _____ _____ _____ _____ _____

2. Grade levels screened _____ _____ _____ _____ _____

STUDENTS SCREENED: Males _____ Females _____ Total _____

NUMBER OF CHILDREN IDENTIFIED AS HAVING SIGNS OF SCOLIOSIS: _____

Number to be screened next year _____

Number referred for orthopedic evaluation _____

Males _____ Females _____

NUMBER WHO WENT FOR EVALUATION (IF AVAILABLE) _____

RESULTS OF MEDICAL EVALUATION:

No Scoliosis _____ Scoliosis _____

Kyphosis _____ Lordosis _____

Other orthopedic problems/found _____

_____

_____

TOTAL HOURS INVOLVED:

Screening _____ Rescreened _____

Referral _____ Follow-up _____

Health Ed. Preparation and Health Clerk Hours _____

(_____ hours x $_____ = $_____)