HEALTH SCREENING

Student: ______________________ Birthdate: __________ Age: ______
Campus: ______________________ Grade: ______ ID#: ______________
Referring Teacher: ______________________ Date: ______________

Please Return Form To: ______________________ Return Date: ______________

VISION SCREENING:

Name of Screener: ______________________ Date of Screening: ______________

Type of Screening: ☐ Snellen ☐ H.O.T.V.

Screened with glasses: ☐ Yes ☐ No

Far Vision:

Right	Left	Both	Results	
20/	20/	20/	Pass	Fail

Near Vision: appears to be adequate for school work based on teacher or nurse report ☐ **Yes** ☐ **No**

Comments: ____

HEARING SCREENING:

Name of Screener: ______________________ Date of Screening: ______________

Type of Screening: Pure Tone Sweep Check @ 25 Decibels

	1000 Hz	2000 Hz	4000 Hz	Results	
Right				Pass	Fail
Left				Pass	Fail

As a result of the vision / hearing screening is there is a need for a recheck? ☐ **Yes** ☐ **No**
Has follow-up treatment been recommended for vision / hearing? ☐ **Yes** ☐ **No**

Comments: ____

HEALTH APPRAISAL:

Does the student exhibit any signs of health or medical problems? ☐ **Yes** ☐ **No**
If yes, please explain: ______________________________
Is there a need for further medical assessment? ☐ **Yes** ☐ **No**
If yes, please explain: ______________________________
Is the student receiving any medication or medical treatment at school? ☐ **Yes** ☐ **No**
If yes, please explain: ______________________________

Additional Comments: ______________________________

For students being considered for or receiving special education services: Student's medical status indicates a need for the nurse to be included in ARD/IEP Meetings: ☐**Yes** ☐ **No**

Signature: ______________________ **Position:** ______________________

Date ______________________