

PLEASE SUBMIT PRIOR TO MARCH 1<sup>ST</sup> EACH YEAR



1245 Wrights Ln, West Chester, PA 19380

Phone: 1-877-932-2923 Fax: 610-514-6008

**MUST BE DATED WITHIN THE CURRENT YEAR** Health Screening Record **REQUIRED FOR EVERY GRADE**

Student Name: \_\_\_\_\_

Date of Screening: \_\_\_\_\_

Student ID Number: \_\_\_\_\_

Grade: \_\_\_\_\_

**Growth Screen**

**Grades 6 - 12 EVERY Year**

Date of Birth	M/F	Today's Date	Height	Weight	BMI for Age	BMI Percentile
	M / F					

BMI less than 5th percentile – underweight      BMI equal to 85<sup>th</sup> to 94<sup>th</sup> percentile – overweight      BMI equal to or greater than 95<sup>th</sup> percentile@ obese

**Vision Screen** Physicians office, please check if you DO NOT test near acuity \_\_\_\_\_ **Grades 6 - 12 EVERY Year**

Far Vision Right Eye	20/20	20/25	20/30	20/40	20/50	20/70	20/100	20/200	P / F	Screened With Correction?
Far Vision Left Eye	20/20	20/25	20/30	20/40	20/50	20/70	20/100	20/200	P / F	Yes
Near Vision Right Eye	20/20	20/25	20/30	20/40	20/50	20/70	20/100	20/200	P / F	
Near Vision Left Eye	20/20	20/25	20/30	20/40	20/50	20/70	20/100	20/200	P / F	No

FAIL = Visual acuity less than 20/30 in either eye or two- line difference between eyes.

**Hearing Screen** Physicians office, please check if you DO NOT test hearing \_\_\_\_\_

**Grades 7&11**

Grade	Right Ear							Left Ear					
	250 Hz	500 Hz	1000 Hz	2000 Hz	4000 Hz	8000 Hz		250 Hz	500 Hz	1000 Hz	2000 Hz	4000 Hz	8000 Hz
25 / 30 Decibels													
Pass/Fail	P / F	P / F	P / F	P / F	P / F	P / F		P / F	P / F	P / F	P / F	P / F	P / F

SWEEP: Check system at 50 db 1000 Hz. Test all HZ at 25 db. FAIL=2 or more tones at 25db.  
 THRESHOLD: Check system at 50 db 1000 Hz. Decrease db by 10 until child no longer hears a tone and increase by 5 until child hears tone again.  
 Record the tone below the tone child hears = threshold of the tone.

Scoliosis Screen	Grades 6 & 7
Circle one: Pass / Fail	If nurse is performing this screen: Was child referred to a physician for evaluation? Yes / No

Parent's please note, if your child(ren)'s health care provider or local health department does not offer ANY of the above screenings, you will need to make arrangements to have your child(ren) screened in our Downingtown office.

Signature of Provider: \_\_\_\_\_ Name/Stamp: \_\_\_\_\_