1245 Wrights Ln, West Chester, PA 19380

Email: nurse@21cccs.org Phone: 484-875-5450 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 85th to 94th percentile – overweight BMI equal to or greater than 95th 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 West Chester office.

Signature of Provider: _____ Name/Stamp:_____