

STUDENT HEALTH ASSESSMENT

Name _____ DOB: _____ Student #: _____

VISION SCREENING

DISTANCE VISION ACUITY

With Glasses/Contacts Without Glasses/Contacts

Test Used: Snellen HOTV Lea Symbol Functional
Results: Visual Acuity R 20/____ L 20/____ PASS FAIL Referred

Comments/Outcome: _____

NEAR VISION ACUITY

With Glasses/Contacts Without Glasses/Contacts
Test Used: HOTV Sloan or equiv. |Lea Symbol| |Functional|
Results: Visual Acuity 20/____
PASS FAIL Referred

Comments/Outcome: _____

OCULAR ALIGNMENT/STEREOACUITY *(school screening required only once)*

Test Used: Random Dot E Butterfly Date Tested: _____
Results: PASS FAIL Referred

Comments/Outcome: _____

COLOR VISION *(school screening required only once)*

Test Used: Creamer Ishihara Block Matching Date Tested: _____
Results: PASS FAIL Referred

Comments: _____

HEARING SCREENING

PURE TONE AUDIOMETRY AT 20 dB:

Results: Check missed frequencies R 1000 | 2000 | 4000 | PASS | FAIL | Referred
L 1000 | 2000 | 4000 | PASS | FAIL | Referred

Otoscopic Exam: TM's Clear R | L | Wax Plugs R | L
PE Tubes R | L | Hearing Aids R | L

Comments/Outcome: _____

PHYSICAL ASSESSMENT

Vital Signs: HR _____ BP _____ Temp _____ RR _____
Growth: Height: _____ %ile _____ Weight: _____ %ile _____ BMI _____ BMI %ile _____
General Appearance: _____

Comments: *(include undiagnosed signs/symptoms of assessment and referral for evaluation)*

HEALTH HISTORY REVIEW – Re-evaluation

Note: Complete this portion only if this is a re-evaluation. (If this is initial evaluation, complete the Initial Health History)

Not Applicable

1. Does this student have a known medical diagnosis, disability or chronic health problem? **Y** **N**
If YES, explain: _____

2. Since the initial evaluation has this student :
 been hospitalized over night for serious illness, surgery or accidents? **Y** | **N**
 taken medication for longer than two weeks? **Y** | **N**
 required medical treatments or supervision for longer than two weeks? **Y** | **N**

Explain all **Y** answers: _____

3. Is this student currently taking any medication or receiving any medical treatment? **Y** **N**

Explain if **Y** answer: _____

4. Describe general health status (physical/mental): _____

MEDICAL CARE

Note: Complete this portion only if this is a re-evaluation.

1. Primary Care Provider: Phone #: _____

2. Other providers/physicians/specialists: _____

3. Medical Insurance: Medicaid/Salud MCO: _____ Medicaid # _____
 Other Insurance/Coverage: _____
 No Insurance Coverage

4. Date of last physical exam: _____ Summary of Findings: _____

5. Date of last dental visit/exam _____ Summary of Findings: _____

Person Providing History: _____

Relationship to Student: _____ If parent, is this the biological parent? **Y** **N**

Home Phone: _____ Work Phone: _____ Cell Phone _____

School Nurse: _____ RN NP

Nurse Signature: _____ **Date:** _____