**FORM D**

**Vision/Hearing Screening**

(Person responsible for completion of this form—*School Nurse*)

Name of Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of School Nurse\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Distance Acuity** | | | **Near Visual Acuity** | | |
| **□**With correction | **□**Without Correction | | **□**With Correction | | **□**Without Correction |
| R 20/\_\_\_\_\_\_ | L 20/\_\_\_\_\_\_ | | R 20/\_\_\_\_\_\_ | | L 20/\_\_\_\_\_\_ |
| Ocular Alignment  (Random Dot E/Stereotest)  □ Pass  □ Fail  □ Did Not Test | | Color Vision  □ Pass  □ Fail  □ Did Not Test | | Motility  □ Pass  □ Fail  □ Did Not Test | |
| Clinical Observation Notes: | | | | | |

If the student fails the above vision screening and warrant further examination by an eye care specialist, complete ***referral to eye care specialist*** attached to this form. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse’s Signature Date of Screening

**Referral to Eye Care Specialist**

Dear Physician and/or Eye Care Specialist,

The following student,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has recently failed the Vision Screening performed at school and may need to be examined by an eye care specialist. Please complete the Eye Care Specialist Report below and return the completed form to the school nurse. A request is also made that you provide the parent/guardian with a copy of the report.

**Eye Care Specialist Report**

|  |  |  |
| --- | --- | --- |
| **Distance Visual Acuity** | Without Correction  R\_\_\_\_\_\_\_\_\_ L\_\_\_\_\_\_\_\_\_ | With Correction  R\_\_\_\_\_\_\_\_\_ L\_\_\_\_\_\_\_\_\_ |
| **Near Visual Acuity** | Without Correction  R\_\_\_\_\_\_\_\_\_ L\_\_\_\_\_\_\_\_\_ | With Correction  R\_\_\_\_\_\_\_\_\_ L\_\_\_\_\_\_\_\_\_ |
| **Overall Findings**:  □ Normal exam, no glasses needed  □ Significant refractive error, glasses needed  □ Strabismus  □ Amblyopia  □ Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Was a prescription for glasses given? ❒Yes ❒No For constant wear? ❒Yes ❒No | | |
| Do you need to see this child again? \_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Recommendations (other than glasses):**  □ Patching □ Atropine drops □ Referral to pediatric specialist  □ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Eye Specialist Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Screening**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone # (office)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any questions, please contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(School Nurse) (Phone #)

Please return a copy of this form to the school nurse at:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Address) (Fax)

**Hearing**

**PURE TONE HEARING SCREENING**

□ Student has known hearing loss □ Student wears hearing aids

**HEARING LEVELS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Right Ear** | **Left Ear** | **Results** |
| 500 Hz | 25 db |  |  | □ Pass □ Fail |
| 1000 Hz | 20 db |  |  | □ Pass □ Fail |
| 2000 Hz | 20 db |  |  | □ Pass □ Fail |
| 4000 Hz | 20 db |  |  | □ Pass □ Fail |
| 6000 Hz | 20 db |  |  | □ Pass □ Fail |

If the student fails to detect tone at any frequency in either ear screen for the following problems listed below. If the student does not present with any of the problems but has failed the hearing screening, and/or if the student has any of the problems present that warrant further examination by a physician, complete ***referral to physician for failed hearing screening*** attached to this form. For students who wear hearing aid(s) and/or have known hearing loss, seek parental consent to release/exchange confidential information with the child’s audiologist.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PROBLEM** | **YES** | **NO** | **RIGHT EAR** | **LEFT EAR** |
| Cerumen Impaction |  |  |  |  |
| Symptoms of ear infection |  |  |  |  |
| Symptoms of cold/flu |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Nurse’s Signature) (Date of Screening)

**Referral to Physician for Failed Hearing Screening**

Dear Physician,

The following student,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has recently failed a hearing screening performed at school and needs to be examined by a physician. Please complete the following report and return the completed form to the school nurse listed below. A request is also made that you provide the parent/guardian with a copy

of the report.

**Results of Examination**

|  |
| --- |
| Diagnosis |
| Recommendations to the Family |
| Recommendations to School |

**Physician Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Screening** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Phone Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any questions, please contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(School Nurse) (Phone #)

Please return a copy of this form to the school nurse at:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Address) (Fax)