

Student: _____ Student #: _____ DOB: _____

Part II: Health

VISION

Date of most recent screening: _____ Type of screening: _____

Name and position of person conducting screening: _____

- Within normal limits without glasses with glasses
 Not within normal limits (see report from ophthalmologist or optometrist)

Yes No As a result of the screening, is there any indication of a need for further evaluation or adjustment? If yes, explain:

Yes No Has any follow-up treatment been recommended? If yes, explain:

HEARING

Date of most recent screening: _____ Type of screening: _____

Name and position of person conducting screening: _____

- Within normal limits unaided aided

Not within normal limits (see report from otologist or audiologist)

Yes No As a result of screening, is there any indication of a need for further evaluation or adjustment? If yes, explain:

Yes No Has any follow-up treatment been recommended? If yes, explain:

HEALTH

Yes No Does this student exhibit signs of health or medical problems? If yes, cite observations:

Yes No Is there a need for further assessment or referral of a medical problem? If yes, explain:

Yes No Is this student receiving any medications at school? If yes, specify:

Yes No Does this student require adaptive equipment or facility adaptation? If yes, specify:

Yes No Does this student come to the clinic frequently with physical complaints (headaches, stomach aches, etc.)? If yes, provide information you can without compromising confidentiality:

Signature: _____ Position: _____ Date: _____