Germantown Municipal School District
Coordinated School Health
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Germantown, TN 38138
Phone: 901-752-7900 Fax: 901-757-6480

SCREENING RESULTS FORM FOR SCHOOL RECORDS

SCREENING RESULTS

School: _____ **Birthdate**:_____ **AGE**:_____

Last Name:_____ **First Name**:_____

Teacher:_____ **Grade**:_____ **Gender:** Male or Female **(circle)**

☐ Routine Screening ☐ Special Ed Request ☐Teacher/Parent Request ☐ Rescreening/Retest

VISION

Vision: ☐ Glasses ☐ Contacts **Last Exam**: ☐ > One Year ☐ < One Year
Glasses: ☐ Broken ☐ Lost ☐ Not Wearing ☐ Refuses to Wear

Acuity: R FAR: 20/____ **L FAR**: 20/____ **R NEAR**: 20/ _____ **L NEAR**: 20/_____
Muscle Balance: ☐ **Passed** ☐ **Failed**

***Suresight:** **R Reliability #:**_____ **R Sphere:**_____ **R cylinder:**_____
L Reliability #:_____ **L Sphere:**_____ **L cylinder:** _____
Comment:_____ Date:_____

HEARING

☐ Hx.of hearing loss/surgery ☐ PE Tubes ☐ Hearing Aid (s) ☐ Rescreening
Otoscope: Cerumen ☐ Drainage ☐ Erythema ☐ Infected/Ruptured Eardrum

Audiometry: ☐ Pass ☐ Fail **Tympanometry**: ☐Pass ☐Fail
R Hz Freq 1000_____ R Hz Freq 2000_____ RHz Freq 4000_____
L Hz Freq 1000_____ L Hz Freq 2000_____ LHz Freq 4000_____

OAE Screening-- R ear: Pass or Refer L ear: Pass or Refer Date:_____
Comment:_____

Vital Statistics:
Blood Pressure: 1) ____/____ **(date)** _____2)____/_____ **(date)** ____ 3) ____/____ **(date)** _____

Ht: _____inches Wt: _____ lbs. BMI:_____

VISION	HEARING	BLOOD PRESSURE	BMI	PULSE	DENTAL	SCOLIOSIS
Passed	Passed	WNL	WNL*	WNL*	Passed	Passed
Failed	Failed	Criteria unmet High or Low	Over	Criteria unmet High or Low	Failed	Failed
Retest	Retest	Retest	Under	Retest		Retest
Referred	Referred	Referred	Referred	Referred	Referred	Referred

*WNL-within normal limits

School Year:_____
Student Last Name_____

OPTIONAL ASSESSMENTS

Dental:

_____1. Immediate Care is recommended for:
□ Pain □ Extensive Decay □ Severe Gum Inflammation

_____2. Care is recommended as soon as possible for:
□ Obvious Decay □Gum Inflammation □Damaged Filling

_____3 Care is recommended when possible for:
□ Symptoms of Early Decay □ Routine Cleaning/Exam needed

Comment: _____

Scoliosis:

Shoulder Elevated _____
Shoulder Blade Prominence _____
Unequal Distance Between Arm and Body _____
Uneven Hips _____
Rib Prominence _____
Lumbar Prominence _____
Kyphosis Increased _____

Date of screening: _____

Negative Referred for 2° screening _____

School Year:_____
Student Last Name_____