Appendix B: Parent/Guardian Notification and Referral Forms

Parent/Guardian Screening Results Notification Form

_____ School System

Address: _____

Phone: _____ Fax: _____

Student Name: _____ Date: _____

Teacher: _____ Grade: _____

School: _____

Dear Parent/Guardian:

Your child recently participated in a vision, hearing, body mass index and blood pressure encouraged by the State of Tennessee. They are effective in revealing common vision and hearing deficiencies, dental problems, and developmental trends. Our school system also screens for scoliosis and oral health issues. It does not substitute for a professional examination.

YOUR CHILD **SCREENED WITHIN NORMAL LIMITS** THE FOLLOWING:

- Vision
- Hearing
- Body Mass Index (BMI)
- Blood Pressure
- Scoliosis
- Dental

If your child did not screen within normal limits on one or more of the above screens, you will be notified by phone and a referral form.

Parent/Guardian Screening Results Notification Form

_____ SCHOOL SYSTEM
Address: _____
Phone: _____ Fax: _____
Student Name: _____ Date: _____
Teacher: _____ Grade: _____ School: _____

Dear Parent/Guardian:

Your child recently participated in a vision, hearing, body mass index and blood pressure encouraged by the State of Tennessee. These screenings are effective in revealing common vision and hearing deficiencies, dental problems, and developmental trends. Our school system also screens for scoliosis and oral health issues. These screening do not substitute for a professional examination.

YOUR CHILD **SCREENED WITHIN NORMAL LIMITS** THE FOLLOWING:
 Vision Hearing Body Mass Index (BMI) Blood Pressure Scoliosis Dental

A **RESCREEN** WILL BE PERFORMED BY NURSING SERVICES FOR:
 Vision Hearing Blood Pressure

WE HAVE ISSUED A **REFERRAL** FOR **VISION**
For the above REFERRAL our observations for your child are listed below. If your child is not under the care of a medical provider, we strongly encourage you to make an appointment for a complete examination and any needed treatment. If your child has already been seen for the above referral, please ask them to fax a report to _____. If your child does not have a medical provider or if you need financial assistance, please call our office. Thank you for your prompt attention to this matter.
Please have the eye doctor complete the form below and mail or fax to the address above. Thank you.

VISION RESULTS: Distance Acuity: 20/ 20/ Near Acuity (optional): 20/ 20/

 Failed Functional Vision Testing: Muscle balance
 Failed Functional Vision Testing: Depth Perception
 Failed Color Perception Screening

WE RECOMMEND YOUR CHILD RECEIVE AN EXAMINATION FROM AN EYE DOCTOR.
To be completed by eye doctor:
This student was seen by me on _____as per your referral. The following recommendations were made:

_____
Glasses prescribed? Yes or No Comments:
_____

_____ _____
Vision Specialist Signature Vision Specialist Phone Number

Parent/Guardian Screening Results Notification Form

_____ SCHOOL SYSTEM
Address: _____
Phone: _____ Fax: _____
Student Name: _____ Date: _____
Teacher: _____ Grade: _____ School: _____

Dear Parent/Guardian:

Your child recently participated in a vision, hearing, body mass index and blood pressure encouraged by the State of Tennessee. These screenings are effective in revealing common vision and hearing deficiencies, dental problems, and developmental trends. Our school system also screens for scoliosis and oral health issues. These screening do not substitute for a professional examination.

YOUR CHILD **SCREENED WITHIN NORMAL LIMITS** THE FOLLOWING:
 Vision Hearing Body Mass Index (BMI) Blood Pressure Scoliosis Dental

A **RESCREEN** WILL BE PERFORMED BY NURSING SERVICES FOR:
 Vision Hearing Blood Pressure

WE HAVE ISSUED A **REFERRAL** FOR **HEARING**
For the above REFERRAL our observations for your child are listed below. If your child is not under the care of a medical provider, we strongly encourage you to make an appointment for a complete examination and any needed treatment. If your child has already been seen for the above referral, please ask them to fax a report to _____. If your child does not have a medical provider or if you need financial assistance, please call our office. Thank you for your prompt attention to this matter.
Please have the hearing specialist complete the form below and mail or fax to the address above. Thank you.

HEARING RESULTS: Failed Audiometry
Signs of Infection: Pain Discharge Wax Erythema
____1. Immediate Care is recommended for the acute symptoms marked above
_____2. Follow-up is recommended as soon as possible for a suspected hearing problem

WE RECOMMEND YOUR CHILD RECEIVE AN EXAMINATION FROM A PHYSICIAN OR AUDIOLOGIST.

To be completed by physician or audiologist:

This student was seen by me on _____as per your referral. The following recommendations were made:

_____

Medication/PE Tubes/Hearing Aids prescribed: Circle One: Yes or No
Comments: _____

_____ _____
Hearing Specialist Signature Hearing Specialist Phone Number

Parent/Guardian Screening Results Notification Form

_____ SCHOOL SYSTEM
Address: _____
Phone: _____ Fax: _____
Student Name: _____ Date: _____
Teacher: _____ Grade: _____ School: _____

Dear Parent/Guardian:
Your child recently participated in a vision, hearing, body mass index and blood pressure encouraged by the State of Tennessee. These screenings are effective in revealing common vision and hearing deficiencies, dental problems, and developmental trends. Our school system also screens for scoliosis and oral health issues. These screening do not substitute for a professional examination.

YOUR CHILD **SCREENED WITHIN NORMAL LIMITS** THE FOLLOWING:
□ Vision □ Hearing □ Body Mass Index (BMI) □ Blood Pressure □ Scoliosis □ Dental

A **RESCREEN** WILL BE PERFORMED BY NURSING SERVICES FOR:
□ Vision □ Hearing □ Blood Pressure

WE HAVE ISSUED A **REFERRAL** FOR **BODY MASS INDEX (BMI)**

For the above REFERRAL our observations for your child are listed below. If your child is not under the care of a medical provider, we strongly encourage you to make an appointment for a complete examination and any needed treatment. If your child has already been seen for the above referral, please ask them to fax a report to _____. If your child does not have a medical provider or if you need financial assistance, please call our office. Thank you for your prompt attention to this matter.
Please have the doctor complete the form below and mail or fax to the address above. Thank you.
BMI RESULT
Call the Coordinated School Health Office _____ for your child's results.

WE RECOMMEND YOUR CHILD RECEIVE AN EXAMINATION FROM A PHYSICIAN
To be completed by physician:
This student was seen by me on _____as per your referral. The following recommendations were made:
_____
_____

_____ _____
Physician Signature Physician Phone Number

Parent/Guardian Screening Results Notification Form

_____ SCHOOL SYSTEM
Address: _____
Phone: _____ Fax: _____
Student Name: _____ Date: _____
Teacher: _____ Grade: _____ School: _____

Dear Parent/Guardian:

Your child recently participated in a vision, hearing, body mass index and blood pressure encouraged by the State of Tennessee. These screenings are effective in revealing common vision and hearing deficiencies, dental problems, and developmental trends. Our school system also screens for scoliosis and oral health issues. These screening do not substitute for a professional examination.

YOUR CHILD **SCREENED WITHIN NORMAL LIMITS** THE FOLLOWING:
 Vision Hearing Body Mass Index (BMI) Blood Pressure Scoliosis Dental

A **RESCREEN** WILL BE PERFORMED BY NURSING SERVICES FOR:
 Vision Hearing Blood Pressure

WE HAVE ISSUED A ***REFERRAL** FOR **BLOOD PRESSURE**
For the above REFERRAL our observations for your child are listed below. If your child is not under the care of a medical provider, we strongly encourage you to make an appointment for a complete examination and any needed treatment. If your child has already been seen for the above referral, please ask them to fax a report to _____. If your child does not have a medical provider or if you need financial assistance, please call our office. Thank you for your prompt attention to this matter.
Please have the doctor complete the form below and mail or fax to the address above. Thank you.

BLOOD PRESSURE RESULT
Date of screen: _____/_____/_____ Blood Pressure Reading: _____/_____

WE RECOMMEND YOUR CHILD RECEIVE AN EXAMINATION FROM A PHYSICIAN
*Referral was based on the American Academy of Pediatrics' guidelines for screening and management of high blood pressure in children and adolescents.

To be completed by physician:
This student was seen by me on _____as per your referral. The following recommendations were made:
_____
_____

_____ _____
Physician Signature Physician Phone Number

Parent/Guardian Screening Results Notification Form

_____ SCHOOL SYSTEM
Address:_____
Phone:_____ Fax:_____
Student Name: _____ Date: _____
Teacher: _____ Grade: _____ School: _____

Dear Parent/Guardian:

Your child recently participated in a vision, hearing, body mass index and blood pressure encouraged by the State of Tennessee. These screenings are effective in revealing common vision and hearing deficiencies, dental problems, and developmental trends. Our school system also screens for scoliosis and oral health issues. These screening do not substitute for a professional examination.

YOUR CHILD **SCREENED WITHIN NORMAL LIMITS** THE FOLLOWING:
 Vision Hearing Body Mass Index (BMI) Blood Pressure Scoliosis Dental

A **RESCREEN** WILL BE PERFORMED BY NURSING SERVICES FOR:
 Vision Hearing Blood Pressure

WE HAVE ISSUED A **REFERRAL** FOR **SCOLIOSIS**
For the above REFERRAL our observations for your child are listed below. If your child is not under the care of a medical provider, we strongly encourage you to make an appointment for a complete examination and any needed treatment. If your child has already been seen for the above referral, please ask them to fax a report to _____. If your child does not have a medical provider or if you need financial assistance, please call our office. Thank you for your prompt attention to this matter.
Please have the specialist complete the information below and mail or fax to the address above. Thank you.

SCOLIOSIS SCREEN RESULT
Your child was given a posture check to screen for curvature of the spine. Your child has signs of a possible curve listed below. This does not mean your child has scoliosis. Only a physician can make that diagnosis. It is recommended that your child have a complete evaluation by your pediatrician or family physician. After the doctor has examined your child and completed this form, please return it to school.

School Screening Findings:

L	R		L	R	
		Shoulder blade more prominent than other			High Shoulder blade
		Obvious curve of spine in upper back			Rib hump
		Obvious curve of spine in lower back			High shoulder
		Obvious curve of spine in aera of rib cage			Hip higher than other side
		Waist to arm space greater			Other:

___Rounded back ____Uneven on best test by ____ degrees
Other:_____

To be completed by physician:

This student was seen by me on _____as per your referral. The following recommendations were made:

_____

_____

_____ _____

Physician Signature Physician Phone Number

Parent/Guardian Screening Results Notification Form

_____ SCHOOL SYSTEM
Address: _____
Phone: _____ Fax: _____
Student Name: _____ Date: _____
Teacher: _____ Grade: _____ School: _____

Dear Parent/Guardian:
Your child recently participated in a vision, hearing, body mass index and blood pressure encouraged by the State of Tennessee. These screenings are effective in revealing common vision and hearing deficiencies, dental problems, and developmental trends. Our school system also screens for scoliosis and oral health issues. These screening do not substitute for a professional examination.

YOUR CHILD **SCREENED WITHIN NORMAL LIMITS** THE FOLLOWING:
 Vision Hearing Body Mass Index (BMI) Blood Pressure Scoliosis Dental

A **RESCREEN** WILL BE PERFORMED BY NURSING SERVICES FOR:
 Vision Hearing Blood Pressure

WE HAVE ISSUED A **REFERRAL** FOR **DENTAL**
For the above REFERRAL our observations for your child are listed below. If your child is not under the care of a medical provider, we strongly encourage you to make an appointment for a complete examination and any needed treatment. If your child has already been seen for the above referral, please ask them to fax a report to _____. If your child does not have a medical provider or if you need financial assistance, please call our office. Thank you for your prompt attention to this matter.
Please have the specialist complete the form below and mail or fax to the address above. Thank you.

ORAL HEALTH RESULT
_____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

WE RECOMMEND YOUR CHILD RECEIVE AN EXAMINATION FROM A DENTIST
To be completed by dental provider:
This student was seen by me on _____as per your referral. The following recommendations were made:
_____

_____ _____
Physician Signature Physician Phone Number