Appendix B: Parent/Guardian Notification and Referral Forms

Parent/Guardian Screening Results Notification Form

School Sy	stem
Address:	
Phone:	Fax:
Student Name:	Date:
Teacher:	Grade:
School:	
Dear Parent/Guardian:	
encouraged by the State of Tennesse deficiencies, dental problems, and de	vision, hearing, body mass index and blood pressure e. They are effective in revealing common vision and hearing evelopmental trends. Our school system also screens for ees not substitute for a professional examination.
YOUR CHILD SCREENED WITHIN NO	
	□ 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.

		SCH	IOOL SYST	ΓEM			
Address:							
Phone:							
Student Name:				Date:			
Teacher:			Gr	ade:	_ School:		
Dear Parent/Guard	an:						
Your child recently encouraged by the and hearing deficie screens for scoliosis examination.	State of Tenness ncies, dental pro	ee. These blems, ar	e screenin nd develo _l	gs are eformental	fective in revealing trends. Our school	commoi system a	also
YOUR CHILD SCREE	NED WITHIN NO	ORMAL L	IMITS THE	E FOLLOV	VING:		
□ Vision □ He	aring 🛮 Body	Mass Ind	ex (BMI)	□ Blood	Pressure 🛮 Scolid	osis 🛮	Dental
A <u>RESCREEN</u> WILL E		BY NURSII Pressure		CES FOR:			
WE HAVE ISSUED A For the above REFE the care of a medic examination and ar please ask them to assistance, please c	RRAL our observal provider, we soly needed treatness a report to If you all our office. Th	ations for trongly er nent. If yo ur child do ank you fo	ncourage our child h oes not ha or your pi	you to m as alread ave a med rompt att	ake an appointmer dy been seen for th dical provider or if y cention to this matt	nt for a c e above /ou need er.	omplete referral, d financial
Please have the eye you.	doctor complet	e the forn	n below a	nd mail d	or fax to the addres	s above.	. Thank
VISION RESULTS:	Distance Acuity	<u>/</u> : 20/	20/	 <u>Ne</u> a	r Acuity (optional):	20/	20/
☐ Failed Functional☐ Failed Functional☐ Failed Color Perce	Vision Testing: D	epth Perd					
WE RECOMMEND		CEIVE AN	EXAMINA	ATION FI	ROM AN EYE DOCT	OR.	
To be completed b					antowal The follows	·	
This student was se recommendations was a second to the student was se	-		as [er your i	referral. The follow	ing	
Glasses prescribed?	Yes or No Co	omments	:				
Vision Sp	ecialist Signature	<u> </u>	_	Vi	sion Specialist Pho	ne Num	ber

	SCHOO	L SYSTEM		
Address:				
Phone:	Fax:			
Student Name:		Date:		
Teacher:		_ Grade:	_ School:	
Dear Parent/Guardian:				
Your child recently participal encouraged by the State of and hearing deficiencies, de screens for scoliosis and ora examination.	ennessee. These sci	reenings are ef evelopmental	fective in revealing cor trends. Our school sys	mmon vision tem also
YOUR CHILD <u>SCREENED WIT</u>				s □ Dental
A RESCREEN WILL BE PERFO		SERVICES FOR:		
WE HAVE ISSUED A REFERRA For the above REFERRAL our the care of a medical provide examination and any neede please ask them to fax a rep	observations for your observations for your observations for your observations for your observations. If your child does	urage you to m child has alread not have a med	ake an appointment for the ald dical provider or if you	or a complete bove referral, need financial
assistance, please call our of Please have the hearing spe Thank you.				
	☐ Discharge are is recommended as so ILD RECEIVE AN EXA	for the acute son as possible	symptoms marked abo for a suspected hearin	ng problem
This student was seen by me		as per you	r referral. The followi	ng
recommendations were made	de:			
Medication/PE Tubes/Hearir Comments:	g Aids prescribed:	Circle One: Yes	or No	
Hearing Specialist S	Signature	————	earing Specialist Phone	Number

SCHOO	L SYSTEM		
Address:			
Phone: Fax:			
Student Name:	Date:		_
Teacher:	Grade:	School:	
Dear Parent/Guardian: Your child recently participated in a vision, heari encouraged by the State of Tennessee. These sc and hearing deficiencies, dental problems, and o screens for scoliosis and oral health issues. The examination.	reenings are e developmental	ffective in reveali trends. Our scho	ing common vision ool system also
YOUR CHILD SCREENED WITHIN NORMAL LIMI Usion Hearing Body Mass Index (coliosis 🏻 Dental
A <u>RESCREEN</u> WILL BE PERFORMED BY NURSING Usion Hearing Blood Pressure	SERVICES FOR		
WE HAVE ISSUED A REFERRAL FOR BODY MASS	INDEX (BMI)		
For the above REFERRAL our observations for you the care of a medical provider, we strongly enco examination and any needed treatment. If your please ask them to fax a report to	urage you to n child has alrea nce, please cal	nake an appointr dy been seen for If your child do our office. Thar	ment for a complete r the above referral, pes not have a nk you for your
Call the Coordinated School Health Office child's results.			for your
WE RECOMMEND YOUR CHILD RECEIVE AN EX To be completed by physician: This student was seen by me on recommendations were made:			
Physician Signature		Physician Pho	ne Number

SCHOOL SYSTEM	
Address:	
Phone: Fax:	
Student Name: Date:	
Student Name: Date: Teacher: Grade:	School:
Dear Parent/Guardian:	
Your child recently participated in a vision, hearing, body mass in encouraged by the State of Tennessee. These screenings are efformed hearing deficiencies, dental problems, and developmental to screens for scoliosis and oral health issues. These screening do examination.	ective in revealing common vision rends. Our school system also
YOUR CHILD <u>SCREENED WITHIN NORMAL LIMITS</u> THE FOLLOW Usion Hearing Body Mass Index (BMI) Blood	
A RESCREEN WILL BE PERFORMED BY NURSING SERVICES FOR: Usion Hearing Blood Pressure	
WE HAVE ISSUED A *REFERRAL FOR BLOOD PRESSURE For the above REFERRAL our observations for your child are listed the care of a medical provider, we strongly encourage you to make a mination and any needed treatment. If your child has already please ask them to fax a report to	ake an appointment for a complete y been seen for the above referral, cal provider or if you need financial ention to this matter.
Please have the doctor complete the form below and mail or fax	c to the address above. Thank you.
BLOOD PRESSURE RESULT Date of screen:/ Blood Pressur	re Reading:/
WE RECOMMEND YOUR CHILD RECEIVE AN EXAMINATION FR *Referral was based on the American Academy of Pediatrics' gui management of high blood pressure in children and adolescents	idelines for screening and
To be completed by physician:	
This student was seen by me onas per your recommendations were made:	eferral. The following
Physician Signature	Physician Phone Number

		SCHOO	OL SYSTEM			
Ctudent Non		Fax:	Data			
Student Nar	ne:		Date: _	C ala a al :		
reacher:			Grade:	School: ₋		
Dear Parent	/Guardian:					
encouraged and hearing	by the State o deficiencies, c scoliosis and o	pated in a vision, heari f Tennessee. These so lental problems, and o ral health issues. Thes	reenings are developmenta	effective in re al trends. Our	vealing com school syste	mon vision em also
YOUR CHILE	SCREENED W	ITHIN NORMAL LIMI	I TS THE FOLL	OWING:		
		☐ Body Mass Index (☐ Scoliosis	□ Dental
	_	FORMED BY NURSING	SERVICES FO	R:		
For the above the care of a examination please ask the assistance, p	re REFERRAL on medical provention and any need hem to fax a response call our	RAL FOR SCOLIOSIS ur observations for your observations for you deep, we strongly encouled treatment. If your export to If your child does office. Thank you for complete the informations.	urage you to child has alre not have a m your prompt	make an app ady been see edical provide attention to t	ointment for n for the abo er or if you n his matter.	a complete ove referral,
Thank you.	the specialist	complete the informa	tion below ar	ia man or tax	to the addre	.ss above.
Your child w possible cur that diagnos family physi to school. School Scre	ve listed below sis. It is recomi	sture check to screen v. This does not mear nended that your chil doctor has examined	n your child h d have a com l your child ar	as scoliosis. (plete evaluat	Only a physicion by your p	cian can make pediatrician or
L R	ıldar blada mara ı	prominent than other	L R	igh Chouldor blac	40	
	ous curve of spine			igh Shoulder blac b hump		
	ous curve of spine			igh shoulder		
		e in aera of rib cage		ip higher than ot	her side	
Wais	t to arm space gre	eater	0	ther:		
Rounde		eater Uneven on best tes		ther:		

To be completed by physician: This student was seen by me on recommendations were made:	as per your referral. The following			
Physician Signature	Physician Phone Number			

SCHOOL SYSTEM	
Address:	
Phone: Fax:	
Student Name: Date:	
Teacher: Grade: Schoo	l:
Dear Parent/Guardian: Your child recently participated in a vision, hearing, body mass index and	•
encouraged by the State of Tennessee. These screenings are effective in and hearing deficiencies, dental problems, and developmental trends. O screens for scoliosis and oral health issues. These screening do not subs examination.	ur school system also
YOUR CHILD SCREENED WITHIN NORMAL LIMITS THE FOLLOWING: Usion Hearing Body Mass Index (BMI) Blood Pressure	e 🛮 Scoliosis 🖺 Dental
A RESCREEN WILL BE PERFORMED BY NURSING SERVICES FOR: Usion Hearing Blood Pressure	
WE HAVE ISSUED A <u>REFERRAL</u> 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 ap	
examination and any needed treatment. If your child has already been so	•
please ask them to fax a report to	
If your child does not have a medical provi	der or if you need financial
assistance, please call our office. Thank you for your prompt attention to	o this matter.
Please have the specialist complete the form below and mail or fax to the	e address above. Thank you.
ORAL HEALTH RESULT	
1. Immediate Care is recommended for:	
☐ Pain ☐ Extensive Decay ☐ Severe Gum Infla	mmation
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/Ex	am needed
WE RECOMMEND YOUR CHILD RECEIVE AN EXAMINATION FROM A DI	ENTIST
To be completed by dental provider:	
This student was seen by me onas per your referral. The follow made:	ving recommendations were
Physician Signature	Physician Phone Number