# STUDENT HEALTH ASSESSMENT

Name ___________________________ DOB: ___________ Student #: ___________

## VISION SCREENING

<table>
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<tr>
<th></th>
<th>With Glasses/Contacts</th>
<th>Without Glasses/Contacts</th>
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**DISTANCE VISION ACUITY**

- **Test Used:**
  - [ ] Snellen
  - [ ] HOTV
  - [ ] Lea Symbol
  - [ ] Functional

- **Results:**
  - Visual Acuity R 20/___  L 20/___  **PASS**  **FAIL**  **Referred**

**Near Vision Acuity**

- **Test Used:**
  - [ ] HOTV
  - [ ] Sloan or equiv.
  - [ ] Lea Symbol
  - [ ] Functional

- **Results:**
  - Visual Acuity 20/___  **PASS**  **FAIL**  **Referred**

**Ocular Alignment/Stereoacuity** (school screening required only once)

- **Test Used:**
  - [ ] Random Dot E
  - [ ] Butterfly

- **Results:**
  - **PASS**  **FAIL**  **Referred**

**Color Vision** (school screening required only once)

- **Test Used:**
  - [ ] Creamer
  - [ ] Ishihara
  - [ ] Block Matching

- **Results:**
  - **PASS**  **FAIL**  **Referred**

## HEARING SCREENING

**Pure Tone Audiometry at 20 dB:**

- **Results:**
  - Check missed frequencies
    - R 1000 2000 4000  **PASS**  **FAIL**  **Referred**
    - L 1000 2000 4000  **PASS**  **FAIL**  **Referred**

**Otoscopic Exam:**

- **TM’s Clear**
  - R  L
- **Wax Plugs**
  - R  L
- **PE Tubes**
  - R  L
- **Hearing Aids**
  - R  L

**Comments/Outcome:**

## PHYSICAL ASSESSMENT

**Vital Signs:**

- HR _____
- BP _____
- Temp _____
- RR _____

**Growth:**

- Height: _____ %ile
- Weight: _____ %ile
- BMI: _____ BMI %ile

**General Appearance:**

**Comments:** (include undiagnosed signs/symptoms of assessment and referral for evaluation)

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Adapted from Albuquerque Public Schools  page 1 of 2
HEALTH HISTORY REVIEW – Re-evaluation

Note: Complete this portion only if this is a re-evaluation. (If this is initial evaluation, complete the Initial Health History)

□ Not Applicable

1. Does this student have a known medical diagnosis, disability or chronic health problem?  Y □  N □
   If YES, explain: ____________________________

2. Since the initial evaluation has this student:
   been hospitalized over night for serious illness, surgery or accidents?  Y □  N □
   taken medication for longer than two weeks?  Y □  N □
   required medical treatments or supervision for longer than two weeks?  Y □  N □

   Explain all Y answers: ________________________________________________

3. Is this student currently taking any medication or receiving any medical treatment?  Y □  N □

   Explain if Y answer: __________________________________________________

4. Describe general health status (physical/mental): ________________________________
   _________________________________________________________________

MEDICAL CARE

Note: Complete this portion only if this is a re-evaluation.

1. Primary Care Provider: ___________________________ Phone #: __________________

2. Other providers/physicians/specialists: ________________________________

3. Medical Insurance:
   Medicaid/Salud MCO: ___________________________ Medicaid #: _____________
   Other Insurance/Coverage: ___________________________
   □ No Insurance Coverage

4. Date of last physical exam: ___________ Summary of Findings: ____________________
   _________________________________________________________________

5. Date of last dental visit/exam ___________ Summary of Findings: __________________
   _________________________________________________________________

Person Providing History: ________________________________

Relationship to Student: ___________________________ If parent, is this the biological parent?  Y □  N □
Home Phone: ___________________________ Work Phone: ___________________________ Cell Phone ___________________________

School Nurse: ___________________________ □RN  □NP
Nurse Signature: ___________________________ Date: ____________