STUDENT HEALTH ASSESSMENT

Name_____ **DOB:**_____ **Student #:**_____

VISION SCREENING

DISTANCE VISION ACUITY
☐With Glasses/Contacts ☐ Without Glasses/Contacts

Test Used: ☐ Snellen ☐ HOTV ☐ Lea Symbol ☐Functional
Results: Visual Acuity R 20/____ L 20/____ **PASS**☐ **FAIL** ☐ **Referred** ☐

Comments/Outcome: _____

NEAR VISION ACUITY
☐With Glasses/Contacts ☐Without Glasses/Contacts
Test Used: ☐HOTV ☐Sloan or equiv. ☐Lea Symbol ☐Functional
Results: Visual Acuity 20/____
PASS ☐ **FAIL** ☐ **Referred** ☐

Comments/Outcome:_____

OCULAR ALIGNMENT/STEREOACUITY *(school screening required only once)*
Test Used: ☐ Random Dot E ☐ Butterfly **Date Tested:**_____
Results: **PASS**☐ **FAIL** ☐ **Referred** ☐

Comments/Outcome: _____

COLOR VISION *(school screening required only once)*
Test Used: ☐Creamer ☐Ishihara ☐Block Matching **Date Tested:** _____
Results: **PASS**☐ **FAIL** ☐ **Referred** ☐

Comments: _____

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)*

_____

_____

_____

HEALTH HISTORY REVIEW – Re-evaluation

Note: Complete this portion <u>only if this is a re-evaluation</u>. ***(If this is initial evaluation, complete the Initial Health History)***
☐ ***Not Applicable***

1. Does this student have a known medical diagnosis, disability or chronic heath 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 <u>only if this is a re-evaluation</u>.

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:**_____