WARREN COUNTY SCHOOLS
Exceptional Children Program

HEALTH SCREENING FORM
(*To be completed by a school nurse*)

Student Name: ______________________________ DOB: _______ Age: ________

Teacher Name: _____________________________ Grade: _____________________

Date of Screening: _________________ Reason for Screening: ________________

Vision Screening

LEFT	**RIGHT**
Near: _____/_____	Near: _____/_____
Far: _____/_____	Far: _____/_____

Hearing Screening

_____ Pass _____ Fail ______dB (intensity level) ______Hz (frequencies)

Physical Health Screening

Height: ___________ This falls in the _______ percentile for his/her age.

Weight: __________ This falls in the _______ percentile for his/her age.

Blood Pressure: _____/_____

Physical Appearance: (Please note any noteworthy physical concerns.)

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____

Medications: (if any)

____

____

____

Other Health Conditions/Concerns:

____

____

____

____
School Nurse