

**Warren County Schools
School Assistance Team
MEDICAL AND HEALTH SCREENING**

1. Visual Acuity

Screening Date: ____/____/____

Test Used for Far Vision: _____

Test Used for Near Vision: _____

Student was tested: With glasses Without glasses

Right Eye	Left Eye	Both Eyes
Far Vision: 20/____ Near Vision: 20/____	Far Vision: 20/____ Near Vision: 20/____	Far Vision: 20/____ Near Vision: 20/____
<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

Comments: _____

Screening Performed by: _____ Position: _____

2. Hearing Screening

Date: ____/____/____ ____ db ____ Hz (frequencies)

Right Ear	Left Ear	Both Ears
<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

Comments: _____

Screening Performed by: _____ Position: _____

3. Dental Screening

Screening Date: ____/____/____

Comments: _____

Screening Performed by: _____ Position: _____

4. Physical Growth & Development Screening

Screening Date: ____/____/____

Height	Weight	Blood Pressure
<input type="checkbox"/> WNL <input type="checkbox"/> BNL	<input type="checkbox"/> WNL <input type="checkbox"/> BNL	<input type="checkbox"/> WNL <input type="checkbox"/> BNL

Comments: _____

Screening Performed by: _____ Position: _____

5. Nutritional Information

Date: ____/____/____

Comments: _____

Screening Performed by: _____ Position: _____