Alachua County Public Schools

Health Services Department

Health Screening Result Form

Place label here containing:
Full Name
Date of Birth, Male or Female
Teacher and Grade

Date of Screening:_____

Dear Parent/Guardian,

The below screening results are not a diagnosis. ***It is recommended that you discuss your child's results with his/her health care provider.*** Call your school nurse if you have any questions or need assistance finding a health care provider.

BMI Screening *(Grades Screened 1, 3, and 6)*

Height:_____ inches Weight:_____ lbs. BMI:_____ BMI Percentage:_____%

- **Underweight:** Less than the 5th percentile
- **Possible Future Health Risk:** 85th to 94th percentile
- **Healthier Range:** 5th to 84th percentile
- **Increased Future Health Risk:** 95th percentile or higher

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VISION Screening *(Grades Screened K, 1, 3, and 6)* Right Eye: 20/_____ Left Eye: 20/_____

☐Results obtained from **kindergarten** health physical conducted within last 12 months

☐Wearing Glasses/Contacts ☐Glasses/Contacts not available for screening ☐Broken/Lost

Vision <u>Rescreened</u> *(If Needed)* *Date:*_____ Right Eye: 20/_____ Left Eye: 20/_____

☐Wearing Glasses/Contacts ☐Glasses/Contacts not available for screening ☐Broken/Lost

<u>P = Pass</u>: 20/40 or below *(in one or both eyes)*

Vision Screening with SPOT VISION DEVICE: ☐PASS Right ☐PASS left ☐Referred

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HEARING Screening *(Grades Screened K, 1, and 6)* **Rescreen in 2 weeks for any referred result*

☐Results obtained from **kindergarten** health physical conducted within last 12 months

Hearing Screening

	1000Hz	2000Hz	4000Hz
Left			
Right			

Hearing <u>Rescreened</u> Date:_____

	1000Hz	2000Hz	4000Hz
Left			
Right			

<u>P = Pass</u>: Able to hear in both ears using 20-25 decibels at 1000, 2000 and 4000 Hz levels.
<u>R = Referred</u>: Unable to hear at one or more of the Hz levels in either ear.

Hearing Screening with CORTI DEVICE: ☐PASS Left ☐PASS Right ☐Rescreen in two weeks

Rescreening Date:_____

Hearing <u>Rescreening</u> with CORTI DEVICE: ☐PASS Left ☐PASS Right ☐Referred

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SCOLIOSIS Screening *(Grades Screened 6)* ☐Normal ☐Questionable

Scoliosis <u>Rescreened</u> *(if needed)* Date:_____ ☐Normal ☐Questionable