

H-10-1

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
Kindergarten-12th Grade Health Assessment

_____ SCHOOL

Student Name _____ DOB _____ Grade/Teacher _____

VISION: Date Screened _____ Date Rescreened _____ Referral Date _____

Screened: with corrective lenses _____ / without corrective lenses _____

Visual Acuity: All children must be able to read the 20/30 line as indicated to pass.

Exception: Refer a student who has a 2 line difference between the eyes. Ex: one eye is 20 /20 and the other eye is 20/30.

Comments: _____

HEARING: Date Screened _____ Date Rescreened _____ Referral Date _____

Test@ 20 dB for 1000 Hz, 2000 Hz and 4000 Hz to pass the screening. Fill in lowest dB heard for each frequency

	1000 Hz	Rescreen	2000 Hz	Rescreen	4000 Hz	Rescreen
Right Ear						
Left Ear						

Comments/observations: _____

GROWTH: Date Screened:_____ Height:_____inches; Weight:_____pounds; BMI:_____/_____%

CURRENT INFORMATION:

_____Review of School Health Record: _____

_____Medications taken at school: _____

FINDINGS:

___Vision is within normal limits

___Failed vision screen – referred for further evaluation

___Hearing is within normal limits

___Failed hearing screen – referred for further evaluation

RECOMMENDATION:: Proceed with testing Hold testing until: _____

Comments:_____

School Nurse Name & Title

Date Form Completed