

# Form H

## Screening Results Documentation Form

Form to be Completed by health care Provider

Name: \_\_\_\_\_ School Year: \_\_\_\_\_  
 I authorize my child's physician to release this completed form to \_\_\_\_\_. Please fax to \_\_\_\_\_.  
 Attention: \_\_\_\_\_ I understand that the requestor will protect this information  
 as prescribed by the Family Educational Rights and Privacy Act (FERPA) and the Health Privacy Act (Including HIPPA).  
 \_\_\_\_\_  
 Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of birth \_\_\_\_\_

### Pure Tone Hearing Screening Results:

	1000	2000	4000	Observation/comments
<b>R</b>	Pass__ (20dB) Not Pass__	Pass__ (20dB) Not Pass__	Pass__ (20dB) Not Pass__	
<b>L</b>	Pass__ (20dB) Not Pass__	Pass__ (20dB) Not Pass__	Pass__ (20dB) Not Pass__	

### EVALUATION RESULTS

Diagnosis: \_\_\_\_\_  
 Treatment Plan: \_\_\_\_\_  
 Comments: \_\_\_\_\_

### Vision Screening Results

Acuity Test:	Uncorrected:	Corrected:	Indicate Type by placing a "X"	Electronic Screener (check one):	Observation/
<b>R</b>	Pass: Non Pass_____	Pass: Non Pass_____	____ Lea 5 ft. ____ Lea 10 ft. ____ Eye Check ____ Solan Chart 10 ft.	<input type="checkbox"/> Suresight <input type="checkbox"/> Retinomax <input type="checkbox"/> JVAS	
<b>L</b>	Pass: Non Pass_____	Pass: Non Pass_____	____ Lea 5 ft. ____ Lea 10 ft. ____ Eye Check ____ Solan Chart 10 ft.	<input type="checkbox"/> Suresight <input type="checkbox"/> Retinomax <input type="checkbox"/> JVAS	
<b>Stereopsis</b>	Pass	Fail	____ Smile (PASS 2) ____ Random Dot E		
<b>Color Vision (Male Only)</b>	Pass	Non Pass	____ Ishihara - 14 plate ____ Pseudoisochromatic color testing - 16 plate ____ Color Vision Testing Made Easy		

### EVALUATION RESULTS

Diagnosis: \_\_\_\_\_  
 Treatment Plan: \_\_\_\_\_  
 Comments: \_\_\_\_\_

<b>Signature of examining Healthcare provider:</b> _____	<b>Date of exam:</b> _____
Address: _____	
Phone: _____	