Chapter 4

Health Screening

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Overview

To address the educational and health needs of students, it is necessary to first assess their physical health and well-being. Health screening techniques allow for early identification of suspected abnormalities. Subsequently, parents and educators can utilize all available health information to plan educational programs and related activities most suited to each student's needs and abilities.

Screening is a traditional part of School Health Services. It centers on vision and hearing since impairment of these senses can interfere with learning, occurs with significant frequency in students, and can be detected with acceptable accuracy by good screening techniques. When referrals from such screening programs result in appropriate examination and corrective measures (which may include classroom placement as well as medical/surgical measures), their value is undeniable.

In addition to vision and hearing, s. 381.0056, F.S. requires provisions for growth and development screening and scoliosis screening.

This type of screening is population based and done on all students designated to receive these screening services, unless parents opt-out in writing. Keep a file of the students that opt out. Individual screening requests by parents or teachers are handled annually on a one-on-one basis.

Populations targeted for mandated screenings are specified in Chapter 64F-6.003, Florida Administrative Code (F.A.C).

- Hearing screening shall be provided, at a minimum, to students in grades kindergarten (K), 1 and 6; to students entering Florida schools for the first time in grades K through 5; and optionally to students in grade 3.
- Vision screening shall be provided, at a minimum, to students in grades K, 1, 3, 6 and students entering Florida schools for the first time in grades K through 5.
- Growth and development screening shall be provided, at a minimum, to students in grades 1, 3, and 6.
- Scoliosis screening shall be provided, at a minimum, to students in grade 6.

Note: Vision and hearing screening should be done for teacher/parent referral of a suspected problem and for students being evaluated for special education placement.

POPULATIONS TO BE SCREENED

Grade	K	1	2	3	6	7	New students to FL: K-5
Vision	**x**	**x**		**x**	**x**		**x**
Hearing	**x**	**x**		(x)	**x**		**x**
Growth & Development		**x**		**x**	**x**		
Body Mass Index (BMI)		**x**		**x**	**x**		
Scoliosis					**x**		

(x) Optional

PRE and POST SCREENING GUIDELINES

The mass screenings for Kindergarten, 1st, 3rd and 6th grade students must be scheduled and completed prior to the December holiday break. Use the following pages as a guideline for when tasks should be completed. Before starting your screenings, **it is high advisable to read Chapter 4** on all of the screening processes and training tools.

At least six weeks before the screening:

- **Coordinate, schedule and confirm** the screening dates, times and location with your school's administrator. Note, based on previous experience, the best locations are libraries and vacant class rooms or portables, etc. If two rooms are used, they must be located very closely to each other. This will enable the proper supervision of your trained volunteers and will also expedite the process.

- My screenings have been scheduled for _____
  (insert date(s) here)

- They will be held/located at _____
  (insert location here – library, room "XX", etc)

- Add the screening dates to your school's **Master Calendar** (check with your administration regarding the testing schedules) and notify your Clay County Health Department RN.

- **Coordinate** your school volunteers. Contact your school's Volunteer Coordinator. Give the screening dates and advise him/her that 8 volunteers will be needed for each day.

- Work with your PE coach to complete heights and weights prior to your actual screening dates. If PE coaches are unable to complete heights and weights prior to the actual screening dates, they will need to be done on the day of mass screenings.

- Schedule training for all of your screening volunteers. Plan on at least an hour to train your volunteers. Only RNs or LPNs can perform scoliosis screenings.

- My volunteer training has been scheduled for _____
  (insert date(s) here)

- Call your volunteers the day before training and again the day before the screenings to remind them of the same.

- Meet with your "screening location staff" (media center staff, etc.) prior to the screening dates to discuss any of their specific concerns or needs.

- Call your Clay County Health Department RN for any additional suggestions.

At least four weeks before the screening:

- **Set up** the screening schedule. Make sure to obtain your School's Administrator's approval on the screening schedule before sharing it with your teachers and faculty. Send the **Notice of Mandated Health Screenings** to the parents of students who will be screened.

- **Hint for scheduling dates:** consult last year's calendar schedule, the picture schedule, or consult your CCHD or fellow School District nurses for suggestions. However, the following will provide a good estimate of how much time to allow for each type of screening:

- KG: Vision & hearing only – 20 minutes per class
  1st grade: Vision, hearing, height and weight (BMI) – 20 minutes per class *
  3rd grade: Vision, height and weight (BMI) – 20 minutes per class *
  6th grade: Vision, hearing, height, weight (BMI) and scoliosis – 30 minutes per class *

  * Subtract 5 minutes per class if the height and weight were done prior to the screening date.

- **Notify the teaching staff** of all pertinent details about the screening. Make sure to explain it to them clearly, and consider several ways to communicate it to them (in-person, by e-mail, phone call, announcement, etc.)

- Provide the screening dates and their individual screening times to each teacher whose students will be screened.

- Remind them that if a student wears glasses, the student should bring the glasses with him/her.

- Remind them of the importance of their promptness and responsibilities in the screening process.

- **Contact Lorraine Hans** in Information Services to request copies of the student labels for the screening forms. Lorraine can be reached by phone at 284-6507 or via e-mail at lhans@mail.clay.k12.fl.us. The labels will be grouped separately by class.

- **After you receive the printed labels,** print 1 copy of the screening sheet, write the screening date on it THEN make the required number of copies. Place the labels on the screening sheets and keep them separated by class. This can be done by a school volunteer.

- **Request the screening equipment** (scales and stadiometer) from the CCSD Student Services office. Becky Moody can be reached by phone at 284-6511 or via e-mail at bmoody@mail.clay.k12.fl.us .

At least two weeks before the screening:

- **Send the Notice of Mandated Health Screenings** to the parents of students who will be screened.

- **Attach any "Opt Out" Notices** you have received from the parents of students to the front of that student's screening form to remind you to NOT include this student in your screenings.

- **Volunteers check height/weight** for 1st, 3rd and 6th grade students. Record the data on the screening results form or class roster. For a sample form, refer to the heights and weights screening log on "2012 – 2013 CCHD School Health Forms and Manual" CD.

- **If you used a class roster** to record the heights and weights, transfer the data to the screening results form. (This can be done by volunteers, but remember this information can be extremely sensitive to some individuals.)

- **Check all the equipment** (Titmus machine, audiometer, scales, stadiometer, etc.) to be used to make sure it's in good working order.

- **Make copies** of the schedule and a list of the volunteers and teachers with their room number and phone extensions.

- **Confirm you have a clinic substitute** and leave specific written instructions for screening day in the sub folder.

The day before the screening:

- **Remind the volunteers** of the date, time and importance of arriving early to allow for adequate training time.

- **Remind the faculty** involved in the screenings of their responsibilities.

- **Gather all supplies** needed for the screening room set-up.

- **Have a reminder** of the screenings announced on the morning and/or daily announcements.

- **If possible, set up the screening space,** have all supplies ready for volunteer training and provide a copy of the list of teachers to each of the volunteers.

Screening Day:

- **If unable to set up the day before the screening,** set up the screening space and have all supplies ready for volunteer training and provide a copy of the list of teachers to each of the volunteers.

- **Announce the "Health screenings are TODAY"** on the morning and/or daily announcements. Remind teachers that applicable students must wear their glasses or contacts.

- **If you screen a student** who does not have a pre-printed label on it, you must write the student's name, ID #, date of birth, gender, grade and teacher's name and room number in the label area.

Post-Screening Day:

- **Review ALL completed** screening result forms:

- Are the name, student ID # and screening results recorded and correct?
- Highlight all failures and whether or not glasses were worn, broken or lost if the student wears glasses. Put all highlighted failures and "opt out" forms on the top of the group of forms for each individual class.
- If any screening results have been omitted, pull the form and rescreen the student for the missed test.
- **Begin the screenings** for any students who were absent on the initial screening date. They should be completed within 2 weeks of the initial testing.
- **Any students who fail** the hearing screening must be retested two weeks after the initial test was done.
- **Enter the screening data** into Focus.

All screening and rescreening should be completed within 2 – 3 weeks of the initial screening date. Afterward:

- **Recheck all forms** one last time for completeness. If the form does not have a pre-printed label on it, write the Student ID #, date of birth, gender, grade and teacher's name and room number in the label area.
- **Send all screening results** to the CCHD for data entry into the SHIP database. Send it via the School District interoffice mail addressed to CCHD School Health, c/o Student Services. Highlight
- **After the screening results** have been entered into SHIP (screening database), the processed screening forms, compiled data reports, individual student health report cards and individual teacher vision, hearing and scoliosis referral reports will be returned to you. They should be returned to you within a month.

After you receive the returned screening results from the CCHD:

- **Copies of any referral forms** have been attached to all failure screening forms. **DO NOT REMOVE!!!**
- **Enter the screening data** into Focus, if you have not done so.
- **After the screening data** has been entered, the actual passing screening forms must be filed in the cumulative health folders. Failure screening forms should be placed in the follow-up (orange) folder until documentation of the outcome is

received or the 3rd contact has been documented by the CCHD nurse. If follow-up is received, failure screening forms may be filed in the cumulative health folders. Keep all follow-up records attached to the screening form.

Notice of Mandated Health Screenings

Dear Parent/Guardian,

School-based health screenings required by Florida Law will be conducted at your child's school on _____.
(insert date)

The following grade levels are required to be screened:

- Kindergarten – Vision and Hearing
- 1st Grade - Vision, Hearing, Height, Weight and BMI.
- 3rd Grade - Vision, Height, Weight and BMI.
- 6th Grade – Vision, Hearing, Height, Weight, BMI and Scoliosis.

Students who wear glasses or contacts MUST wear them for this screening process.

If you **DO NOT** want your student screened in any of these areas, you must notify the school **IN WRITING** prior to the screening date. The note is to be given to your School Nurse and must include the student's name, the type of screening you do not want done, your signature and the date.

If you have any questions, concerns or need more information please contact:

School Nurse _____ Phone _____

Vision Screening

Overview

Vision Screening and eye examinations are essential for detecting visual impairment. Conditions that lead to visual abnormalities may lead to inadequate school performance and prevent students from obtaining maximum benefits from their educational experience. Undetected impairments of the visual process can lead to potential decrease in learning ability and problems in school adjustment.
Procedures:

- Vision screeners use 10 ft. Snellen Charts or Good Light Charts and Titmus machines. They should be 42" from the floor for Snellen symbol charts (kindergarten) and 48" from the floor for Snellen alpha chart.
- Kindergartners who fail must be rescreened on the Snellen chart in the health room.
- Students who cannot see the critical line for acuity are re-screened (except for Kindergarten) on the Titmus. If they do not pass the initial screening and the re-screening on the Titmus machine, then they are referred.
- Students, who normally wear corrective lenses but do not have them at screening, will be screened without them.
- Upon completion of the screening (including documentation), School Health Designees will receive a list of all students who have been referred.
- A letter requesting an exam by an eye care specialist will be sent to the parents of those students who do not pass the screening. The eye specialist is asked to complete a section of the letter and the parents are to return it to the school health office or school health designee.
- Any family who cannot afford care may be referred to the appropriate community agency for assistance with authorization from the parent.
- At the end of the screening, all of the results are to be entered in the health record. At a minimum, the Kindergarten data should be entered into Focus.
- Data should be kept on those who have been followed up regarding failure notices, so the CCHD School Nurse can input the outcome data in HMS.

Passing Criteria for Vision Screening

Grades:	**Pre-K and K 5 years and under**	**20/40 each eye**
	K over the age of 6 and older	**20/30 each eye**

Hearing Screening

Overview

The purpose of school hearing screening is to identify students with a hearing loss that may affect their intellectual, emotional, social, speech, and/or language development. A subtle hearing loss may be overlooked resulting in developmental or academic delays. Even mild hearing losses may be educationally and medically significant.

Procedures:

- Initial screenings are done on audiometers by the school nurse or those trained by the school nurse.
- Each ear is screened at 25 decibels on 3 frequencies (1000, 2000 and 4000). Failures are re-screened in 2-4 weeks. Pure-tone criteria for failure are not hearing two frequencies in one ear or the same frequency in both ears.
- A letter requesting an exam by the child's physician is sent to the parents of those students who fail the re-screen. The parent is asked to notify the school health office or health designee of the outcome.
- Any family who cannot afford care may be referred to the appropriate community agency for assistance with authorization from the parent.
- All results are to be entered in the health record. At a minimum, the Kindergarten data should be entered into Focus.
- Data should be kept on those who have followed up regarding failure notices, so the CCHD School Nurse can input the outcome data in HMS.

Scoliosis Screenings

Overview

Scoliosis is an abnormal curvature of the spine usually developing in pre-adolescents and adolescents during rapid growth spurts. Early detection can prevent scoliosis from progressing and can identify those in need of treatment.

Procedures:

- Screenings are conducted by a Public Health Nurse or trained nurse using a scoliometer.
- All screeners using a scoliometer should adhere to the recommended referral parameter range of 7° or greater. Failures are re-screened in 2 - 4 weeks.
- Referral letters will be sent home to advise parents of outcomes and recommend physician follow-up.
- All results are to be entered in the health record.
- Data should be kept on those who have followed up regarding failure notices so the CCHD School Nurse can input the outcome data in HMS.

Growth & Development Screening

Overview

Height and weight measurements provide a simple, effective method of identifying potential childhood health problems. These measurements can be used as an educational tool for parents, students, and school personnel.

Height and Weight Screening Process

- These measurements will be conducted at the individual school by a team designated by the school administration.
- A digital scale and stadiometer are available through Student Services at the CCSB Administration office.
- An inservice of its use may be coordinated with the CCHD School Team.
- The data should be collected on homeroom class lists, and then given to the School Health designee.
- Height should be recorded in inches to ¼"
- Weight should be recorded in pounds to 0.1 lbs.
- This information is then recorded on the screening form and used for BMI calculation. Height and weights need to be on the screening sheets before they are sent to the Health Department for processing.

Body Mass Index Screening

Overview

BMI is a screening tool used to identify individuals who are underweight or overweight. BMI is the recommended screening method for children and adolescents.
It is based on a child's age and gender calculated using height and weight compared to standardized growth charts. This calculation determines if the child is in the normal range for height and weight or outside the norm, and identifies individuals who may have increased potential to develop certain chronic diseases during childhood or adulthood.

Screening Guidelines:
BMI-for-Age Parameters as per CDC recommendations

- > 95th percentile Obese
- 85th to 95th percentile Overweight
- 5th to 85th percentile Normal
- < 5th percentile Underweight

Parents will receive results on screened children with referrals for those students that are obese and underweight.

Data should be kept on those who have followed up regarding failure notices so the CCHD School Nurse can input the outcome data in HMS.

School Health Information Program (SHIP)

The Clay County Health Department School Team coordinates data entry of all screening data into the State approved School Health Information Program (SHIP).

This program generates a “health report card” of the screening results for each student screened. The report cards, as well as referral letters, are sent home with each student.

School
Student ID #
Name
Grade
Teacher
Affix Health Screening Label

Health Screening Form

Date: ___/___/___

Opt-out
☐ Vision ☐ Growth/Development
☐ Hearing ☐ Scoliosis

Clay County Florida
Public Health

VISION - TEST 1
5 years old - Fail if > 20/40
6 + years old - Fail if > 20/30

SNELLEN
Date ___/___/___

Child wears prescription glasses OR contacts
Worn for test ☐ Left at home ☐ Broken/Lost ☐

RIGHT 20/___
LEFT 20/___

RESULTS: PASS ☐ FAIL ☐

REQUIRES RESCREEN ☐

Comments: _____

VISION - TEST 2
5 years old - Fail if > 20/40
6 + years old - Fail if > 20/30

SNELLEN ☐ **TITMUS** ☐
Date ___/___/___

Child wears prescription glasses OR contacts
Worn for test ☐ Left at home ☐ Broken/Lost ☐

RIGHT 20/___
LEFT 20/___

RESULTS: PASS ☐ FAIL ☐

2nd referral notice sent ___/___/___
3rd contact made ___/___/___

Vision referral attached

Parent follow-up received Yes ☐ No ☐

HEARING - TEST 1
Fail: > 25 db on two or more results

PURE TONE
Date ___/___/___

RESULTS: PASS ☐
FAIL ☐

RIGHT db	LEFT db
1000 ____	1000 ____
2000 ____	2000 ____
4000 ____	4000 ____

REQUIRES RESCREEN ☐

Rescreen student in 2 weeks

Comments: _____

HEARING - TEST 2
Fail: > 25 db on two or more results

PURE TONE
Date ___/___/___

RESULTS: PASS ☐
FAIL ☐

RIGHT db	LEFT db
1000 ____	1000 ____
2000 ____	2000 ____
4000 ____	4000 ____

2nd referral notice sent ___/___/___
3rd contact made ___/___/___

Hearing referral attached

Parent follow-up received Yes ☐ No ☐

GROWTH/DEVELOPMENT
Referral made if BMI for age percentile is < 5% (underweight) OR > 95% (obese)

Date ___/___/___

Height in Inches: _____
Records partial inches using 2 decimal places (ex. 43.75 in) and round DOWN to nearest quarter inch

Weight in Pounds: _____
Use actual Reading, using 1 decimal place - example: 90.5 pounds

BMI referral attached

Parent follow-up received Yes ☐ No ☐

SCOLIOSIS - TEST 1
Referral made if curvature is 7% or greater

Curvature: _____ degrees

Date ___/___/___

RESULTS: PASS ☐
FAIL ☐

REQUIRES RESCREEN ☐

SCOLIOSIS - TEST 2
Referral made if curvature is 7% or greater

Curvature: _____ degrees

Date ___/___/___

RESULTS: PASS ☐
FAIL ☐

2nd referral notice sent ___/___/___
3rd contact made ___/___/___

Scoliosis referral attached

File in Cumulative Folder

Parent follow-up received Yes ☐ No ☐

REVISED: 07/01/2012

Screening Opt Out Form

School : _____

0610 Vision Screening Opt-Out

Grade	Number of students opted out
K	
1	
3	
6	

0615 Hearing Screening Opt-Out

Grade	Number of students opted out
K	
1	
6	

0621 HT/ WT/ BMI Screening Opt-Out

Grade	Number of students opted out
1	
3	
6	

0661 Scoliosis Screening Opt-Out

Grade	Number of students opted out
6	

****

Student Screening Request Sample:

Clay County School District

Teacher: _____ Date _____

Please send _____ to the health room at your earliest convenience for vision and hearing screening. Student must bring glasses with him/her.

Thank you,

Example of Screening Report Card sent to parents:

Tuesday, November 08, 2011

To the Parents of:

Student ID:

School Name:

Teacher:

We are concerned about the health and wellness of our students. The Clay County Health Department and your child's school checks elementary students for vision, hearing, scoliosis and growth and development. Height, weight and body mass index (BMI) are used to measure a child's growth. Muscle mass and body fat are not factors that determine BMI. The BMI percentile is used to predict a child's health risk factors.

Healthy living improves a child's behavior, health, grades, attendance and self esteem. Overweight children have more risk of developing chronic diseases such as heart disease and diabetes. Underweight children have more risk for bone loss, nutritional deficiencies and an increased risk of illness.

According to the Centers for Disease Control and Prevention (CDC), the childhood BMI percentile scale is as follows:

Less than 5% - Underweight
5%-84% - Healthy Weight
85% - 94% - Overweight
Greater than or Equal to 95% - Obese

The school district recently screened your child and the results are below. If your child is outside of the healthy ranges in vision, hearing, scoliosis and/or growth, please read the enclosed letters. If you are having difficulty finding help for your child's needs, please contact the school nurse. After visiting the doctor, please return the enclosed completed referral report to the school nurse.

Growth and Development	*Height*	*Weight*	*BMI*	*BMI%*
Vision	#Error *Far* R 20/ #Err L 20/ #Err			
Hearing	#Error			
Scoliosis	#Error			

Clay County School District/Clay County Health Department
NOTIFICATION OF GROWTH AND DEVELOPMENT REFERRAL

Recently, your child was screened for Body Mass Index (BMI) at their school. This calculation tells us if a child is in the healthy range for height and weight, or is at risk to develop certain chronic diseases during childhood or adulthood. Your child's actual BMI results are on the "report card" along with the results of the other screenings that were done on your child.

Your Child's Name: **BUDDY BOY** Student ID: **123456** Grade: **3** Teacher: **WHATSHERNAME,**
Your child's BMI percentile is: **99%**

☐ Underweight	**Under 5th%**	If you have not done so already, please discuss with your child's doctor.
☐ Healthy Weight	**5th to 84th %**	Do not take good health for granted! Monitor diet, activity and weight.
☐ Overweight	**85th% to 94th**	If you have not done so already, please discuss this concern with your child's doctor. This is very important if your family has a history of high blood pressure, high cholesterol, diabetes, heart trouble, etc
☐ Obese	**Greater than or Equal to 95th%**	If you have not done so already, please discuss this concern with your child's doctor. This is very important if your family has a history of high blood pressure, high cholesterol, diabetes, heart trouble, etc

Regardless of the BMI, good nutrition & plenty of physical activity are recommended for all children.
For more information go to the following website for practical tips and tools on how your family can maintain a healthy weight by making better food choices, increasing physical activity and more: http://www.cdc.gov/healthyweight/children/index.html

Doctor's Report
To be completed by a Medical Doctor. Please return this form to your school nurse after the appointment.

Findings: _____

Recommendations: _____

_____

Doctor's Name: _____

Doctor's Signature: _____ **Date:** _____

Or you may check one of these choices and return this form to your School Nurse within two weeks.

☐ I have already discussed this with my child's doctor.

☐ I do not want to do anything about my child's BMI at this time.

Parent/ Guardian Signature: _____ **Date:** _____

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

Vision Referral Log

Dear Teacher: _____ School/Grade: _____

The following is a listing of the students in your class who did not pass the vision screening recently conducted at your school. The parents of these students are being notified. Some of your students may also be re-screened for possible hearing problems in the coming weeks. If you receive information that a student has seen an eye doctor, or if you have a student in need of assistance, please advise your school nurse.

Student Name	Student Number	Vision Results	Saw Eye Doctor	Received Glasses/ Contacts
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		

06/2012

Thursday, July 05, 2012

NOTIFICATION OF VISION REFERRAL

Clay County Florida
Public Health

Teacher *Student ID*

Grade

Dear Parent or Guardian.

Your child has recently completed one or several screening tests, including vision, hearing, and/or scoliosis. These tests are provided by the Clay County School District and the Clay County Health Department. The screening tests are not the same diagnostic tools used by a physician and other health care providers. They are designed for screening purpose only. If the child fails the vision screening, it indicates the possibility that a condition may be present that could affect the child's learning ability. Results of the vision screening indicate that a health care provider evaluation is recommended for your child.

Please complete one of the boxed entries and include any comment.

☐ My child **is currently** under a doctor's care for vision problems. (It is not necessary to make a separate appointment but you may wish to notify the doctor of this report and schedule any additional appointments required.)

PLEASE PROVIDE: Doctor's Name: _____ Phone Number _____

☐ My Child **is not currently** under a doctor's care for vision problems. I have notified a doctor of this report. I have scheduled an appointment on _____ date _____ for my child. I will return the bottom half of this form with the doctor's comments after the exam.

Other comments: _____

Parent/Guardian Signature: _____ Date: _____

Cut and return this portion after exam.

Student ID #

Parent /Guardian: Please provide your current telephone number _____ guardian's current telephone/ cell number _____

Doctor's Report

(This section to be completed only by a licensed vision professional and returned to school after the exam.)

Findings: _____

Recommendation _____

Doctor's Name _____ Date Completed _____

Doctor's Signature _____ Phone: _____

If there are any questions about the screening results or you need assistance with provider referrals, please contact:

Your Child's School Nurse.

8/27/2009

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

REFERRAL FOR VISION EXAMINATION
REPORT TO PARENTS

School_____ Teacher _____

Child's Name _____ Grade _____ Date _____

Your child's eyes were screened by the school nurse as one of the health services provided by this school in order to identify students who have vision problems or might be at risk for vision problems. The vision of students is very important, especially for classroom learning, so it is important to identify any barrier to learning that can be corrected.

Your child's school vision screening results suggest that he/she should have a complete professional eye exam. It is important to your child's school success to have a professional evaluation. If a problem is found and corrected, it may help your student do better in his/her school work.

Just because there are no complaints about vision, you should not assume that your child has perfect vision. Often children do not know they should be able to see better than they do.

Results of school screening with glasses R 20/ ____ L 20/_____

Results of school screening without glasses R 20/ ____ L 20/_____

Financial assistance may be available through various agencies for those unable to pay. Please contact me at _____ if finances are a concern and you do NOT have insurance, need help in getting the eye exam, or your child is already under a doctor's care for vision problems.

_____
School Nurse Signature

DOCTOR'S REPORT TO SCHOOL

Date of eye exam _____

Visual acuity without glasses R 20/ ____ L 20/_____

Visual acuity with glasses R 20/ ____ L 20/_____

Diagnosis

_____

No glasses needed _____ Correction prescribed: Glasses _____ Contact lenses _____

Glasses are to be worn for: Consistent Use _____ Near Vision Only _____ Distance Vision Only _____

Comments or suggestions as to specific needs for child's school program (equipment, seating):

_____

Physician's Signature _____

Address _____

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

SCHOOL HEALTH REFERRAL
VISION FOLLOW-UP
(2nd Notice)

School: _____ **Grade:** _____

Child's Name: _____ **Teacher:** _____

Dear Parent,

About a month ago, I sent a note to you which recommended that your son or daughter have an eye examination to determine if glasses are needed. Please answer the below questions and return this form to the health room to let me know what follow-up has happened or is planned. If financial issues prevent you from seeking this health care, please call me at the below number. If I am not available, please leave your name and phone number and a convenient time to return your call. If I have not heard from you within 30 days, the Clay County Health Department School Health Team nurse will contact you by phone. If you have any questions, please call me. Thank you.

Sincerely,

_____
School Health Nurse

_____
Phone Number

Was a doctor's examination obtained? _____ Yes _____ No
If Yes:

Were glasses needed? _____ Yes _____ No
If Yes:

Were glasses obtained? _____ Yes _____ No

If No:
A doctor's appointment has been made for _____
Appointment date

_____
Parent's Signature

06/2012

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

School ________________________ **Date _____________**

Hearing Referral Log

Student	Student Number	Teacher	Grade	R results	L results	Saw Dr.	Outcome
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
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06/2012

Thursday, July 05, 2012

NOTIFICATION OF HEARING REFERRAL

Clay County Florida Public Health

Teacher *Student ID*

Grade

Dear Parent or Guardian.

Your child has recently completed one or several screening tests, including vision, hearing, and/or scoliosis. These tests are provided by the Clay County School District and the Clay County Health Department. The screening tests are not the same diagnostic tools used by a physician and other health care providers. They are designed for screening purpose only. If the child fails the hearing screening, it indicates the possibility that a condition may be present that could affect the child's learning ability. Results of the hearing screening indicate that a health care provider evaluation is recommended for your child.

Please complete one of the boxed entries and include any comment.

☐ My child is currently under a doctor's care for hearing problems. (It is not necessary to make a separate appointment but you may wish to notify the docto of this report and schedule any additional appointments required.)

PLEASE PROVIDE: Doctor's Name: _____ Phone Number _____

☐ My Child is not currently under a doctor's care for hearing problems. I have notified a doctor of this report. I have scheduled an appointment on _____ date _____ for my child. I will return the bottom half of this form with the doctor's comments after the exam.

Other comments: _____

Parent/Guardian Signature: _____ Date: _____

Cut and return this portion after exam.

Student ID #

Parent /Guardian: Please provide your current telephone number _____ guardian's current telephone/ cell number _____

Doctor's Report

(This section to be completed only by your child's health care provider and returned to school after the exam.)

Findings: _____

Recommendation _____

Doctor's Name _____ Date Completed _____

Doctor's Signature _____ Phone: _____

If there are any questions about the screening results or you need assistance with provider referrals, please contact:

Your Child's School Nurse.

8/27/2009

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

REFERRAL FOR HEARING EXAMINATION
REPORT TO PARENTS

School_____ Teacher _____

Child's Name _____ Grade _____ Date _____

The School Health Services program routinely screens students for possible hearing problems in order to identify any difficulty to learning that might be corrected. Screening programs are important for these reasons:

- They identify students with possible hearing problems.
- Temporary hearing loss causes students to miss essential instructions in the classroom.
- Parents may not be aware of a child's mild hearing loss in every day home situations.
- Even mild losses may interfere with learning new vocabulary, which is important for success in Reading.
- Hearing loss is invisible and the child may be blamed for not paying attention.
- Hearing loss may be sign of ear disease.
- Children with very mild losses or loss in only one ear may be experiencing school failure.

Your child failed our screening and rescreening for hearing problems. It is important to your child's school success to have a professional evaluation. If a problem is found and corrected, it may help your child to do better in his or her school work. Enclosed is a referral form to take to your physician or speech and language specialist. It is important to us to know the outcome of the professional examination, so please return the form to us with the results of the exam. If there are circumstances that prevent you from taking your child to the doctor, your child is already under a doctor's care, or if you have any questions, please call your school nurse.

_____
School Nurse Signature

DOCTOR'S REPORT TO SCHOOL

Please provide the school nurse named above with the results of this evaluation so that the school may be informed and make any necessary adaptations and/or do monitoring of the child's condition.

_____

_____

_____

_____
Physician's Signature Date

_____
Address

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

SCHOOL HEALTH REFERRAL
HEARING FOLLOW-UP
(2nd Notice)

School: _____ **Grade:** _____

Child's Name: _____ **Teacher:** _____

Dear Parent,

About a month ago, I sent a note to you recommending that your son or daughter have an examination by a physician or Speech and Hearing Specialist of your choice to determine if your child has an actual hearing loss. Please answer the below questions and return this form to the health room to let me know what follow-up has happened or is planned. If financial issues prevent you from seeking this health care, please call me. If I am not available, please leave your name and phone number and a convenient time to return your call. If I have not heard from you within 30 days, the Clay County Health Department School Health Team nurse will contact you by phone. If you have any questions, please call me at the below number. Thank you.

Sincerely,

_____
School Health Nurse

_____
Phone Number

Was a doctor's examination obtained? _____ Yes _____ No
If Yes:

Was a hearing deficit confirmed? _____ Yes _____ No
If Yes:

Was treatment obtained? _____ Yes _____ No

Please explain:

_____

_____

If No:
A doctor's appointment has been made for _____
Appointment date

_____
Parent's Signature

06/2012

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

School _____ **Date** _____

Scoliosis Referral Log

Student	Student Number	Teacher	Saw Dr.	Outcome

Thursday, July 05, 2012

NOTIFICATION OF SCOLIOSIS REFERRAL

Clay County Florida Public Health

Teacher *Student ID*

Grade

Dear Parent or Guardian,

Your child has recently completed one or several screening tests, including vision, hearing, and/or scoliosis. These tests are provided by the Clay County School District and the Clay County Health Department. The screening test are not the same diagnostic tools used by a physician and other health care providers. They are designed for screening purpose only. If the child fails the scoliosis screening, it indicates the possibility that a condition may be present that could affect the child's learning ability. Results of the scoliosis screening indicate that a health care provider evaluation is recommended for your child.

Please complete one of the boxed entries and include any comment

☐ My child **is currently** under a doctor's care for scoliosis problems. (It is not necessary to make a separate appointment but you may wish to notify the doctor of this report and schedule any additional appointments required.)

PLEASE PROVIDE: Doctor's Name: _____ Phone Number _____

☐ My Child **is not currently** under a doctor's care for scoliosis problems. I have notified a doctor of this report. I have scheduled an appointment on _____ date _____ for my child. I will return the bottom half of this form with the doctor's comments after the exam.

Other comments: _____

Parent/Guardian Signature: _____ Date: _____

Cut and return this portion after exam

Student ID #

Parent /Guardian: Please provide your current telephone number _____ guardian's current telephone/ cell number _____

Doctor's Report

(This section to be completed only by a licensed professional and returned to school after the exam)

Findings: _____

Recommendation _____

Doctor's Name _____ Date Completed _____

Doctor's Signature _____ Phone: _____

If there are any questions about the screening results or you need assistance with provider referrals, please contact:

Your Child's School Nurse.

8/27/09

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

SCHOOL HEALTH REFERRAL
SCOLIOSIS FOLLOW-UP
(2nd Notice)

School: _____ **Grade:** _____

Child's Name: _____ **Teacher:** _____

Dear Parent,

About a month ago, I sent a note to you recommending that your son or daughter have an examination by a physician of your choice to determine if your child has an actual abnormality of the spine. Please answer the below questions and return this form to the health room to let me know what follow-up has happened or is planned. If financial issues prevent you from seeking this health care, please call me. If I am not available, please leave your name and phone number and a convenient time to return your call. If I have not heard from you within 30 days, the Clay County Health Department School Health Team nurse will contact you by phone. If you have any questions, please call me at the below number. Thank you.

Sincerely,

_____
School Health Nurse

_____
Phone Number

Was a doctor's examination obtained? _____ Yes _____ No
If Yes:

Was an abnormality of the spine confirmed? _____ Yes _____ No
If Yes:

Was treatment obtained? _____ Yes _____ No

Please explain:

_____

_____

If No:
A doctor's appointment has been made for _____
Appointment date

_____
Parent's Signature

06/2012

Height and Weight Screening Log
(Required for only 1st, 3rd and 6th grades)

Grade: ___ Teacher: _____ Date: _____

Student Name	Student Number	Height	Weight

06/2012

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