

Form: K

Screening Results Documentation Form

Form to be Completed by Healthcare 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 _____

Childs' Name _____ Date of Birth _____

Pure Tone Hearing Screening Results

	1000	2000	4000	Observation/Comments:
R	Pass_____ (20 dB)	Pass_____ (20 dB)	Pass_____ (20 dB)	
	Non Pass_____	Non Pass_____	Not Pass_____	
L	Pass_____ (20 dB)	Pass_____ (20 dB)	Pass_____ (20 dB)	
	Non Pass_____	Non Pass_____	Not Pass_____	

EVALUATION RESULTS:

Diagnosis: _____

Treatment Plan: _____

Comments: _____

Vision Screening Results

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

EVALUATION RESULTS:

Diagnosis: _____

Treatment Plan: _____

Comments: _____

Signature of examining Healthcare Provider: _____	Date of exam: _____
Address: _____	
Phone: _____	