LAUREL SCHOOL DISTRICT HOMESCHOOL/CYBER PROGRAMS
SCREENINGS ARE TO BE COMPLETED EVERY YEAR

STUDENT'S NAME: ______________________________ DOB: ________________________________

GRADE: _________ DATE OF SCREENING: _______________________

HEIGHT: (ALL GRADES) _____________WEIGHT: (ALL GRADES)__________

BMI: (ALL GRADES)_____________BMI %:___________________________

VISION: (ALL GRADES)

FAR: RIGHT 20/____ LEFT 20/__ [ ] PASS [ ] FAIL

NEAR: RIGHT 20/____ LEFT 20/__ [ ] PASS [ ] FAIL

DOES THIS CHILD WEAR GLASSES/CONTACTS? ____
IF "YES" WERE THEY WEARING THEM FOR THE VISION SCREENING?__
WAS THE CHILD REFERRED FOR FURTHER VISION EVALUATION? _____

OTHER VISION (GRADE K-2 ONLY)

COLOR VISION [ ] PASS [ ] FAIL
STEREO/DEPTH PERCEPTION [ ] PASS [ ] FAIL
CONVEX LENS [ ] PASS [ ] FAIL

HEARING (GRADES K, 1,2,3, 7, 11 AND ANY CHILD WITH HISTORY OF HEARING LOSS)

	250HZ	500	1000	2000	4000	PASS/FAIL	REFERRED
RIGHT dB							
LEFT dB							

SCOLIOSIS (GRADES 6 & 7) TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
[ ] PASS [ ] FAIL REFERRED? ____________
COMMENTS:____
____

MEDICAL PROVIDER SIGNATURE: ________________________________
ADDRESS: ____

SCREENING DATE: ________________________