Building Excellence
Health Services

School:_____ **Date:**_____

Student:_____ **Teacher:**_____

I request that my child have his / her vision and hearing screened by the school nurse. Results will be reported to my child's teacher and a referral letter will be sent home if needed.

_____ _____ _____
Parent/Guardian Signature Date Phone Number

Teacher's and/or Parent Concerns:

_____

_____

_____

For Nurse's Use Only

Vision	**Hearing**	
Far_____	Right	Left
_____	1000_____	_____
_____	2000_____	_____
Near_____	4000_____	_____
_____	8000_____	_____
_____		

Results of today's screening: Passed or Failed

My child has insurance: Yes _____ No_____

If yes, name of insurance company: _____

I need assistance in taking my child to a licensed provider: Yes_____ No_____