LIONS DISTRICT 27-D2
STUDENT HEALTH SCREENING FORM

STUDENT NAME:

STUDENT AGE/GRADE:

Date of Screening: _____

Name of Screener: _____

VISION:

Wears glasses? (Circle) YES NO

Screened with glasses? (Circle) YES NO

Vision Screening Method: (Circle) SPOT Plus Optix Chart

(Circle) PASS REFER

Comments: _____

HEARING: (Circle) PASS REFER

	1000 Hz/20 dB	2000 Hz/20 dB	4000 Hz/20 dB
Right Ear			
Left Ear			

*Place an 'X' in the boxes that did NOT Pass.

RECHECKS:

Date of Vision Rescreen: _____

Distance Vision with Sloan: Right Eye: 20/____ Left Eye: 20/____ PASS FAIL

Date of Hearing Rescreen: _____ PASS FAIL

	1000 Hz/20 dB	2000 Hz/20 dB	4000 Hz/20 dB
Right Ear			
Left Ear			

*Place an 'X' in the boxes that did NOT Pass.

Comments: