VISION-HEARING-MEDICAL SCREENING

Case Study Committee Referral

Student_____ Date of Birth_____

Teacher_____ Grade_____

Vision: Date Screened_____

	Without Glasses	*With Glasses*
Distance	R 20/_____ L/_____	R 20/_____ L/_____
Near	R 20/_____ L/_____	R 20/_____ L/_____

Instrument Used: ❒ Titmus ❒ Random Letter ❒ Tumbling E ❒ Preschool Symbols

PERRLAEOM: _____

Remarks:_____

Hearing: Date Screened_____

Testing frequencies @ 20 or 25 db. Indicate db at which student heard sound.

	500	**1000**	**2000**	**4000**
Right				
Left				

Canals: ❒ Pink ❒ Erythema TM's: ❒ Clear ❒ Opaque ❒ PE tubes

Remarks:_____

Current Medical Information:

Medications:_____

Minor neurological signs: ❒ Achieved ❒ Difficulty with_____

Findings Indicate: (Check all that apply)

- ❒ Vision within normal limits
- ❒ Hearing within normal limits
- ❒ Classroom performance may be adversely affected
- ❒ One-on-one testing may be adversely affected
- ❒ No additional medical concerns at this time
- ❒ Other_____

CSC Testing/Follow-up: ❒ Proceed with testing ❒ Hold testing

Signature School Nurse_____ Date_____