Form: K

Ohio Department of Health

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_____			
L	Pass:	Pass:	_____ Lea 5 ft. _____ Lea 10 ft. _____ Eye Check _____ Sloan Chart 10 ft	Suresight/Retinomax/JVAS	
	Non Pass_____	Non Pass_____			
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: _____	_____

HEA #0144