STUDENT HEALTH RECORD – Middletown Christian Schools

NAME OF STUDENT_____

VISION SCREENING (TEST WITH GLASSES IF WORN)

Date	Grade	Visual Acuity			Plus Lens	M.B.	Color
		Right	Left	Both			
	K						
	1						
	2						
	3						
	4						
	5						
	6						
	7						
	8						

Date:_____ Suspected:_____

Referred to Eye Doctor:_____ Completed Referral:_____

New Case:_____

HEARING TESTS AUDIOGRAMS (Screening Results)

Date	**Right Ear**						**Left Ear**					
	250	500	1000	2000	4000	8000	250	500	1000	2000	4000	8000

Referred for Hearing Loss Yes____ No____

Under Treatment for Hearing Problem Yes____ No____

Hearing Problem Corrected Yes____ No____

Student has Permanent Hearing Loss Yes____ No____

Right Ear_____ Left Ear_____

SPEECH

Does the student have a speech problem? Yes____ No____

SPECIFY

Gr.	Ht.	Wt.	Gr.	Ht.	Wt.	Gr.	Ht.	Wt.	Gr.	Ht.	Wt.
K			3rd			5th			7th		
1st			4th			6th			8th		
2nd											

Notes: **P** – Principal / **T** – Teacher / **N** - Nurse
Ps – Psychologist / **Dr**. – Doctor