



Georgia Department of Public Health Form 3300

PLEASE SEE THE INSTRUCTIONS
ON THE BACK OF THIS FORM

Certificate of Vision, Hearing, Dental, and Nutrition Screening

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

Parent/ Guardian Name: _____ first _____ middle _____ last _____
Parent/ Guardian Contact Information: _____
 Daytime phone number: _____
 Evening phone number: _____
 Cell phone number: _____

Child's Name: _____ first _____ middle _____ last _____
Date of Birth: ____/____/____ **Gender:** Male Female
Child's Home Address: _____ street _____ city _____ state _____ zip code _____ county _____

VISION	HEARING	DENTAL	NUTRITION
<input type="checkbox"/> Unable to screen (explain why below) <input type="checkbox"/> Uses corrective lenses <input type="checkbox"/> Worn for testing <input type="checkbox"/> Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6) <input type="checkbox"/> Needs further evaluation <input type="checkbox"/> Under professional care (explain below) Screening completed by: <input type="checkbox"/> Physician <input type="checkbox"/> Local Health Department <input type="checkbox"/> Optometrist <input type="checkbox"/> "Prevent Blindness Georgia" employee <input type="checkbox"/> School Registered Nurse Screeneer's Signature _____ Date _____ <i>I certify that this child has received the above screening.</i> Contact Information: _____	<input type="checkbox"/> Unable to screen (explain why below) <input type="checkbox"/> Uses hearing aid / assistive device <input type="checkbox"/> Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB <input type="checkbox"/> Needs further evaluation <input type="checkbox"/> Under professional care (explain below) Screening completed by: <input type="checkbox"/> Physician <input type="checkbox"/> Local Health Department <input type="checkbox"/> Audiologist <input type="checkbox"/> Speech-Language Pathologist <input type="checkbox"/> School Registered Nurse Screeneer's Signature _____ Date _____ <i>I certify that this child has received the above screening.</i> Contact Information: _____	<input type="checkbox"/> Unable to screen (explain why below) <input type="checkbox"/> Normal appearance <input type="checkbox"/> Needs further evaluation <input type="checkbox"/> Emergency problem observed <input type="checkbox"/> Under professional care (explain below) Screening completed by: <input type="checkbox"/> Physician <input type="checkbox"/> Dentist <input type="checkbox"/> Local Health Department Registered Nurse <input type="checkbox"/> Registered Dental Hygienist <input type="checkbox"/> School Registered Nurse Screeneer's Signature _____ Date _____ <i>I certify that this child has received the above screening.</i> Contact Information: _____	<input type="checkbox"/> Unable to screen (explain why below) Height: _____ Weight: _____ BMI: _____ BMI%: _____ <input type="checkbox"/> 5 th to 84 th percentile - Appropriate for age <input type="checkbox"/> < 5 th percentile - Needs further evaluation <input type="checkbox"/> ≥ 85 th percentile - Needs further evaluation <input type="checkbox"/> Under professional care (explain below) Screening completed by: <input type="checkbox"/> Physician <input type="checkbox"/> Local Health Department <input type="checkbox"/> Registered Dietician <input type="checkbox"/> School Registered Nurse Screeneer's Signature _____ Date _____ <i>I certify that this child has received the above screening.</i> Contact Information: _____

FOR SCHOOL SYSTEM ONLY		Follow up for further evaluation
1 st attempt	2 nd attempt	Actions reported (if any)
Vision		
Hearing		
Dental		
Nutrition		
Student support services initiated on: _____		
Screeners' Comments: _____		