# Georgia Department of Public Health
**Form 3300**

**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

- [ ] Unable to screen (explain why below)
- [ ] Uses corrective lenses
- [ ] Worn for testing
- [ ] Passed (20/20 in each eye for age 6 and above, 20/40 in each eye for below age 6)
- [ ] Needs further evaluation
- [ ] Under professional care (explain below)

Screening completed by:
- [ ] Physician
- [ ] Local Health Department
- [ ] Optometrist
- [ ] "Prevent Blindness Georgia" employee
- [ ] School Registered Nurse

**Screener’s Signature** Date: __________

I certify that this child has received the above screening.

**Contact Information:**

### HEARING

- [ ] Unable to screen (explain why below)
- [ ] Uses hearing aid / assistive device
- [ ] Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
- [ ] Needs further evaluation
- [ ] Emergency problem observed
- [ ] Under professional care (explain below)

Screening completed by:
- [ ] Physician
- [ ] Local Health Department
- [ ] Audiologist
- [ ] Speech-Language Pathologist
- [ ] School Registered Nurse

**Screener’s Signature** Date: __________

I certify that this child has received the above screening.

**Contact Information:**

### DENTAL

- [ ] Unable to screen (explain why below)
- [ ] Normal appearance
- [ ] Needs further evaluation
- [ ] Emergency problem observed
- [ ] Under professional care (explain below)

Screening completed by:
- [ ] Physician
- [ ] Dentist
- [ ] Local Health Department Registered Nurse
- [ ] Registered Dental Hygienist
- [ ] School Registered Nurse

**Screener’s Signature** Date: __________

I certify that this child has received the above screening.

**Contact Information:**

### NUTRITION

- [ ] Unable to screen (explain why below)
- [ ] 5th to 84th percentile - Appropriate for age
- [ ] < 5th percentile - Needs further evaluation
- [ ] ≥ 85th percentile - Needs further evaluation
- [ ] Under professional care (explain below)

Screening completed by:
- [ ] Physician
- [ ] Local Health Department
- [ ] Registered Dietician
- [ ] School Registered Nurse

**Screener’s Signature** Date: __________

I certify that this child has received the above screening.

**Contact Information:**

### FOR SCHOOL SYSTEM ONLY

<table>
<thead>
<tr>
<th>Follow up for further evaluation</th>
</tr>
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<tbody>
<tr>
<td>1st attempt</td>
</tr>
<tr>
<td>Vision</td>
</tr>
</tbody>
</table>

**Screeners’ Comments:**

[ ]

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