

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Student Services
30 East Texar Drive,
Pensacola, FL 32503 Phone: (850) 469-5382

VISION / HEARING SCREENING REQUEST

Student's Legal Name: (Last, First, Middle)		DOB:		Student Number:	
Grade:	Teacher:	Form to be returned to:	Date Requested:	Date Received by Clinic Staff:	

VISION SCREENING RESULTS: Has parent given written consent? Yes ___ No ___ Written consent is required.

Date: _____

Examiner: _____

Does the student have a Healthcare Plan? Yes ___ No ___

Does the student wear glasses? Yes ___ No ___

Does the student wear contacts? Yes ___ No ___

Screened with glasses/contacts? Yes ___ No ___

Snellen: Right _____ Left _____ Pass ___ Fail ___

Near Point: Right _____ Left _____ Pass ___ Fail ___

Stereo: Pass ___ Fail ___

Spot Vision Screening Results: Pass ___ Fail ___

Comments: _____

Recommend Rescreen by RN: Yes ___ No ___

Referred to: _____ Date: _____

Pass/Fail Criteria for Vision:
Snellen Results:
Ages 3-5 years old: 20/40 = Pass; 20/50 = Fail
Age 6 and older: 20/30 = Pass; 20/40 = Fail
Stereo Results:
Ages 3-5 years old: See fly or 2 of 3 animals = Pass
Age 6 and older: 6 of 9 circles = Pass
Near Point Results:
Ages 3-5 years old: 20/40 = Pass; 20/50 = Fail
Age 6 and older: 20/30 = Pass; 20/40 = Fail
Spot Vision Screener Results:
All Measurements in Range = Pass
Complete Eye Exam Recommended = Fail

RESCREENING BY RN RESULTS:

Date: _____

Examiner: _____

Does the student wear glasses/contacts? Yes ___ No ___

Screened with glasses/contacts? Yes ___ No ___

Comments: _____

Snellen: Right _____ Left _____ Pass ___ Fail ___

Near Point: Right _____ Left _____ Pass ___ Fail ___

Stereo: Pass ___ Fail ___

Referred to: _____ Date: _____

(If student has private vision exam, attach copy of results.)

HEARING SCREENING RESULTS: Has parent given written consent? Yes ___ No ___ Written consent is required.

Date: _____

Examiner: _____

Right Ear: Pass ___ Fail ___

Left Ear: Pass ___ Fail ___

Comments: _____

Recommend Rescreen Yes ___ No ___

Referred to: _____ Date: _____

Pass/Fail Criteria for Hearing for all ages: 20 dB at 1000, 2000 and 4000 Hz = Pass
(25 dB may be used for Pass if room is not quiet) 30+ dB at any frequency = Fail

RESCREENING RESULTS:

Date: _____

Examiner: _____

Right Ear: Pass ___ Fail ___

Left Ear: Pass ___ Fail ___

Comments: _____

Referred to: _____ Date: _____

(If student receives audiological evaluation, attach copy of results.)