Germantown Municipal Schools COORDINATED SCHOOL HEALTH STUDENT HEALTH SCREENING FORM

School:_____Birth Date:_____Age:_____

Last Name:_____First Name:_____

Teacher:_____Grade:_____Gender: (Male or Female)

Height: _____ in. **Weight**: _____ lbs. **Body Mass Index**: _____ Percentile: _____

Blood Pressure: Systolic _____ Diastolic _____

****Height & Weight must NOT include decimals or fractions. Round to nearest whole number!**

Vision: (pass or fail)

	Right	Left
Near	_____	_____
Far	_____	_____

Glasses / Contacts (circle only if wearing)

Hearing: (pass or fail)

	Right	Left
1000 Hz	_____	_____
2000 Hz	_____	_____
4000 Hz	_____	_____

RESCREEN INFORMATION

Blood Pressure: Systolic _____ Diastolic _____ Date_____ Time_____

Systolic _____ Diastolic _____ Date_____ Time_____

Vision: (pass or fail)

	Right	Left
Near	_____	_____
Far	_____	_____

Glasses / Contacts (circle only if wearing)

Date_____

Hearing: (pass or fail)

	Right	Left
1000 Hz	_____	_____
2000 Hz	_____	_____
4000 Hz	_____	_____

Date_____

FINAL SCREENING RESULTS:		
TYPE OF SCREENING	WITHIN NORMAL RANGE	PHYSICIAN REFERRAL RECOMMENDED
BODY MASS INDEX		
BLOOD PRESSURE		
VISION		
HEARING		
SCOLIOSIS (6TH GRADE ONLY)		