# 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
*PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM*

**Child's Name:** first middle last

**Date of Birth:** month day year

**Gender:** ☐ Male ☐ Female

**Child's Home Address:** street, city, state, zip code county

**Parent/Guardian Name:**

**Parent/Guardian Contact Information:**
Daytime phone number: Cell:
Evening phone number:

### VISION

☐ Unable to screen (explain why below)
☐ Uses corrective lenses
☐ Worn for testing

☐ Passed (20/30 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
☐ 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)

**Height:** _____ **Weight:** _____

**BMI:** _____ **BMI%:** _____
☐ 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** Follow up for further evaluation

| | 1st attempt | 2nd attempt | Actions reported (if any) |
|---|---|---|---|
| Vision | | | |
| Hearing | | | |
| Dental | | | |
| Nutrition | | | |

Student support services initiated on:

Screeners' Comments:

[DPH Form 3300 Rev. 2013]