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

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 (20/30 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:

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