

General Health Screening Evaluation

Student Name _____ DOB _____ Age _____

School _____ Teacher _____ Grade _____

Physical Exam

Height _____ Weight _____

Visual and Hearing Screening

Date Tested _____

				Normal	Abnormal	Not Tested
Far Acuity	Both	Right	Left			
Near Acuity	Both	Right	Left			
Referral Sent	Yes	No				
Color Perception						
Extra Ocular Movement						
Hearing Screening						

Examination For Minor Neurological Signs

	Age Appropriate	Questionable	Abnormal
Finger to nose			
Finger opposition			
Diadochokinesis			
One-foot standing balance			
One foot hop			
Walking of tip toes			
Walking on heels			
Skipping			
Upper body muscle strength			
Lower body muscle strength			

Medications taken at home: _____

Medications taken at school: _____

Educationally significant problems: (seizures, diabetes, asthma, heart condition etc.)

Nurse Signature _____ Date _____