Georgia Department of Public Health

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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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