Follow-Up Screening Verification Form

Name of Child: ____

Birthdate: ___/_______/________ Date of Screening: _____ / _____ / ______

Hearing screening information:	Vision screening information:
❑ Pass ❑ Fail ❑ Uncooperative ❑ Referred: _________________ ❑ Rescreen in __ weeks/months Concerns related to student's hearing:	❑ Pass ❑ Fail ❑ Uncooperative ❑ Referred: _________________ ❑ Rescreen in __ weeks/months Concerns related to student's vision:

Dental Screening Information:

- ❑ No Obvious Problems
- ❑ Possible problem areas, check at next dental apt
- ❑ Dental attention is needed as soon as possible
  - ❑ Referred to dentist
  - ❑ Already under dentist's care

Health Care Professional's Certification

I certify that I performed the screening(s) listed above on the above named student. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: ____ Title: _____________________________

Signature: ____ Date (m/d/yyyy): _____________________

Practice/Clinic Name and address:			Provider Stamp Here:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Revised 1/27/2020 jw