

Date: _____

Polk County Special Services
US-287, Corrigan, TX 75939
Phone: (936) 225-5446

EDUCATIONAL SCREENING/EXISTING EVALUATION DATA

NAME OF STUDENT

DATE OF BIRTH

ID#

GRADE

CAMPUS

Health Information

VISION

Date of most recent screening: _____ Type of screening: _____

Name and position of person conducting screening: _____

Far Vision: Results: ☐ Passed without glasses/contacts ☐ Passed with glasses/contacts

☐ Failed without glasses/contacts ☐ Failed with glasses/contacts

Close Vision: Results: ☐ Passed without glasses/contacts ☐ Passed with glasses/contacts

☐ Failed without glasses/contacts ☐ Failed with glasses/contacts

☐ Yes ☐ No As a result of the screening, is there any indication of a need for further assessment or adjustment? If **Yes**, explain:

☐ Yes ☐ No Has any follow-up treatment been recommended? If **Yes**, explain:

HEARING

Date of most recent screening: _____ Type of screening: _____

Name and position of person conducting screening: _____

Results: ☐ Passed without hearing aids ☐ Passed with hearing aids

☐ Failed without hearing aids ☐ Failed with hearing aids

☐ Yes ☐ No As a result of the screening, is there any indication of a need for further assessment or adjustment? If **Yes**, explain:

☐ Yes ☐ No Has any follow-up treatment been recommended? If **Yes**, explain:

HEALTH

☐ Yes ☐ No Does student exhibit any signs of health or medical problems? If **Yes**, cite observations:

☐ Yes ☐ No Is there a need for further assessment or referral of a medical problem? If **Yes**, explain:

☐ Yes ☐ No Is the student receiving any medication at school? If **Yes**, specify:

☐ Yes ☐ No Does this student require adaptive equipment or facility adaptation? If **Yes**, specify:

SIGNATURE OF PERSON COMPLETING THIS SECTION

POSITION

DATE