Health Screening Results

Child's Name: ____ Date: _________________________
Your child received a health screening today. The results are checked below. If a re-check is necessary, it will be done within 4 weeks.

Vision	Hearing
☐ Passed ☐ Needs to be re-screened ☐ Needs a referral Comments: _________________________________ ____ ____	☐ Passed ☐ Needs to be re-screened ☐ Needs a referral Comments: _________________________________ ____ ____

Growth Assessment	
Height _____________ Weight _____________ ☐ Needs to be re-screened ☐ Needs a referral	Comments: _________________________________ ____ ____ ____

Health Screening Results

Child's Name: ____ Date: _________________________
Your child received a health screening today. The results are checked below. If a re-check is necessary, it will be done within 4 weeks.

Vision	Hearing
☐ Passed ☐ Needs to be re-screened ☐ Needs a referral Comments: _________________________________ ____ ____	☐ Passed ☐ Needs to be re-screened ☐ Needs a referral Comments: _________________________________ ____ ____

Growth Assessment	
Height _____________ Weight _____________ ☐ Needs to be re-screened ☐ Needs a referral	Comments: _________________________________ ____ ____ ____