Georgia Department of Public Health
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

Child's Name: first middle last

Date of Birth: month day year

Gender: ☐ Male ☐ Female

Child's Home Address: street, city, state, zip code county

Parent/Guardian Name:

Parent/Guardian Contact Information:
Daytime phone number: Cell:
Evening phone number:

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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