

APPENDIX E
Alabama First Class Pre-K Program
CHILD HEALTH SCREENING RECORD

To be completed by nurse or trained professional (NOT Pre-K teacher or OSR Director)

Class Name: _____ County: _____

Student Name: _____ Date of Birth: _____ / _____ / _____
Last First Middle

VISION

HEARING

DENTAL

PHYSICAL

Date _____

Date _____

Date _____

Date _____

Check one for each eye:

Check one for each ear:

Results:

Results:

Left: Pass Fail

Left: Pass Fail

___ Should see a dentist

Height: _____

Right: Pass Fail

Right: Pass Fail

___ Normal exam/no concerns

Weight: _____

Comments:

Comments:

Additional Notes: _____

Body Mass Index (BMI): _____

Blood Pressure: _____

Concerns/Recommendations:

Child missed screening due to:

Child missed screening due to:

Child missed screening due to:

Child was not screened due to:

- Absent
- Parent permission denied
- Child non cooperative
- Enrollment after screening

- Absent
- Parent permission denied
- Child non cooperative
- Enrollment after screening

- Absent
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- Absent
- Parent permission denied
- Child non cooperative
- Enrollment after screening

Signature of Screener

Signature of Screener

Signature of Screener

Signature of Screener

Date

Date

Date

Date