



Coordinated Student Health Services

School Health Training

TERMS A06 PANEL CODES

State Mandated Health Screenings are conducted every year for students in specific grade levels; Kindergarten, First, Third and Sixth.

These grade levels receive the following screenings:

Kindergarten – Vision and Hearing

First – Vision, Hearing and BMI

Third – Vision and BMI

Sixth – Vision, Hearing, BMI and Scoliosis

Screening results are entered into TERMS on the A06 panel.

Referral follow-up results are entered by the IMT on the A06 panel.



Student's Name: _____ Grade: _____

School: _____ Teacher: _____ Student Number: _____

Glasses/contacts worn during screening: Yes / No

Visual Screening Results Using Threshold Charts

Screening Date: _____

Right Eye	Left Eye
20/_____	20/_____

Circle Overall Results:

PASS *REFER

***Student unable to correctly identify 3 out of 5 symbols/letters on line 20/32 in either eye**

Comments: _____

Your child **did not pass** the Vision Screening Test done at school. This screening was done to detect possible vision or eye problems that could affect your child's learning. **It is important that you contact a physician or eye care professional as soon as possible to follow-up on these findings.** If you need any help or financial assistance to do this, please contact the school.

We need to know that you received this notice and follow-up. Please complete the bottom portion of this form and return to the school as soon as possible.

Child was examined by (doctor) _____ on (date) _____

Check one:

- No further treatment was recommended**
- My child has an upcoming appointment or has seen an eye doctor this school year**
- Treatment was recommended for the following condition _____**
- My child received glasses**

Parent/Guardian Signature _____ Date _____



HEARING SCREENING RESULTS (Completed by Screening Personnel in ink)

First Screening

Mark an **X** in box for the sounds **not** heard
 500 Hz omitted due to background noise

	500Hz <small>(20-30dBHL)</small>	1000Hz <small>(20dBHL)</small>	2000Hz <small>(20dBHL)</small>	4000Hz <small>(20dBHL)</small>
Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Screening Results: Pure tone AND/OR OAE
(Otoacoustic Emissions) DPOAE Pass Refer
 Pass (Place in health/cum folder) R
 Fail (Rescreen) L
 CNS *(Could Not Screen; Retry -- second screening)

Comments: _____

Certified Screener (Signature) _____ Date _____

Second Screening

Mark an **X** in box for the sounds **not** heard
 500 Hz omitted due to background noise

	500Hz <small>(20-30dBHL)</small>	1000Hz <small>(20dBHL)</small>	2000Hz <small>(20dBHL)</small>	4000Hz <small>(20dBHL)</small>
Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Screening Results: Pure tone AND/OR OAE
(Otoacoustic Emissions) DPOAE Pass Refer
 Pass (Place in health/cum folder) R
 Fail (Contact Audiologist) L
 CNS *(Could Not Screen -- Contact Audiologist)

Comments: _____

Certified Screener (Signature) _____ Date _____

AUDIOLOGICAL FOLLOW-UP AND RECOMMENDATIONS (Completed by Audiologist)

Otoacoustic Emissions screening (DPOAE)

Pure Tone Screening <small>(20 dBHL at 1.25KHz)</small>			Air Conduction Thresholds (dB HL)								Tympanometry <small>(daPa)</small> <small>(Mobility within the middle ear system)</small>		Canal Volume <small>(ml)</small>		Pass Refer		Otosopic Observation	
			Pass	Fail	Hz	500	1000	2000	3000	4000	6000	8000	R	L	R	L		
R	<input type="checkbox"/>	<input type="checkbox"/>	R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L	<input type="checkbox"/>	<input type="checkbox"/>	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

- | | |
|--|--|
| <input type="checkbox"/> Passed hearing screening | <input type="checkbox"/> Cleared for further educational testing |
| <input type="checkbox"/> Failed hearing screening | <input type="checkbox"/> Medical Referral provided to parent |
| <input type="checkbox"/> Hearing within normal limits | <input type="checkbox"/> Preferential seating/classroom strategies provided to the teacher |
| <input type="checkbox"/> Middle ear function abnormal | <input type="checkbox"/> Information Gathering form provided to the teacher |
| <input type="checkbox"/> No further recommendations at this time | <input type="checkbox"/> Cleared for further educational testing using special testing conditions:
quiet well lit-room, one-to-one, facing speaker to optimize visual/auditory cues |

Audiologist: _____ Date: _____

Form Control #4532 Copies: Cumulative School Health Record; School ESE Folder; Audiologist



Notice to Parent/Guardian of Scoliosis Screening Results

To the Parent(s) of:

Name: _____ Date: _____

Grade: _____ Date of Birth: _____ Age: _____

Dear Parent/Guardian:

In a recent screening program, your child displayed possible scoliosis, or curvature of the spine. Please see the attached copy of your child's *Scoliosis Screening Procedure Worksheet*. Further evaluation is recommended to determine if treatment is necessary. The effect of scoliosis depends upon its severity, how early it is detected, and how promptly it is treated.

Please have your child examined by your family physician.
Please have the examining physician complete the form below and return it to the school.

We need to know that you have received this notice and obtained follow-up. Please complete this portion and return it to the school as soon as possible.

Student's Name _____ School _____

Child was examined by (Doctor) _____ on (date) _____.

Check one:

- No further treatment was recommended.
 Treatment was recommended for the following condition: _____

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____ Date: _____



Student Label Here

BMI SCREENING RESULTS FORM

Student's Name: _____ Gender: _____ DOB: _____ Age: _____

School: _____ Grade: _____ Student Number: _____

Screening Date: _____ Teacher: _____ Pass: _____ Refer: _____

Screening Results: Height (in) _____ Weight (lb) _____ BMI _____ BMI% _____

Screener Please Circle

- | | | |
|--|--|---|
| <input type="checkbox"/> (< 5%) 0522 | Increased risk for health problems | Medical assessment recommend |
| <input type="checkbox"/> (≥ 5% to < 85%) 0521 | Height and weight are within normal range. | No action is necessary |
| <input type="checkbox"/> (≥ 85% to < 95%) 0523 | Increased risk for future chronic diseases.
Also consider additional risk factors such as
Family history, blood pressure, cholesterol, etc., | Consider a medical assessment if child has additional risk factors. |
| <input type="checkbox"/> (≥ 95%) 0524 | Increased risk for chronic diseases. | Medical assessment recommend |



YOU ARE THE GREATEST ADVOCATE FOR YOUR CHILD'S HEALTH.

Dear Parent or Guardian:

The Broward County Public School District knows that good health is important for learning. Healthy weight screenings are provided at your child's school to screen for weight categories that may lead to health problems.

One way to measure healthy weight is by using Body Mass Index (BMI). BMI is based on your child's weight, height, gender and age. High BMI scores can be related to risk for health problems like diabetes, asthma, high blood pressure and others. BMI does not distinguish between fat and muscle.

Keep in mind, checking a child's growth over time is more important than a one-time measurement and it is necessary for all children, regardless of BMI, to be active and eat healthy.

Information from your child's BMI screening is found below.

BMI PERCENTILE GUIDE		
SCREENER PLEASE CIRCLE APPLICABLE BMI PERCENTILE:		
BMI Percentile:	Description	Action
<5% Less than 5th percentile	Increased risk for potential health problems.	Medical evaluation highly recommended.
≥5% to <85% 5th percentile to less than 85th percentile	Height and weight are within typical range.	Continued health screenings and education recommended to maintain a healthy weight.
≥85% to <95% 85th to less than the 95th percentile	Increased risk for future chronic diseases, such as diabetes. Consider other risk factors such as family history, blood pressure, and high cholesterol, etc.	Medical evaluation recommended.
≥95% Equal to or greater than the 95th percentile	Increased risk for potential chronic diseases.	Medical evaluation highly recommended.

A FOLLOW-UP EVALUATION BY YOUR CHILD'S HEALTH CARE PROVIDER IS RECOMMENDED.

- My child has been evaluated by his/her healthcare provider this school year.
- My child has an upcoming appointment with his/her health care provider this school year.
- I choose not to share this information with my health care provider

Please sign and return to school after you have reviewed the information.

Date: _____ Student Name: _____

Teacher Name: _____ Parent/Guardian Signature: _____



Eat at least five servings of vegetables and fruits per day



Spend no more than 2 hours a day in front of a screen



Get at least one hour of physical activity every day



No sugary beverages



Screening Item	Code For TERMS (A06)
Opted Out by Parent/Guardian	P
Unable to Screen	U
Screened <ul style="list-style-type: none"> Passed Test 	Y
Screened <ul style="list-style-type: none"> Failed Test 	N
Not Screened <ul style="list-style-type: none"> In Treatment 	I
Absent <ul style="list-style-type: none"> Out, absent will be screened by school 	O
Student withdrawn from school	W

Screening Referral Item	Code For TERMS (A06)
Screened <ul style="list-style-type: none"> Failed Test Received Follow-up 	T
Parent/Guardian refusal to obtain follow-up	R
No response from Parent/Guardian to three documented follow-up attempts	A

BMI 4 Digits Codes

1 st box code 0522 (< 5%) - underweight
2 nd box code 0521 (5% - < 85%) - normal weight
3 rd box code 0523 (≥ 85% - < 95%) - overweight
4 th box code 0524 - (≥ 95%) obese



Contact information

Thank you!

If you have any questions or concerns please contact:

Coordinated Student Health Services 754-321-1575

Edna Soomans, RN Clinical Nurse 954-492-7288



The School Board of Broward County, Florida

Donna P. Korn, Chair

Dr. Rosalind Osgood, Vice Chair

Robin Bartleman

Ann Murray

Patricia Good

Lori Alhadeff

Heather P. Brinkworth

Laurie Rich Levinson

Nora Rupert

Robert W. Runcie

Superintendent of Schools

The School Board of Broward County, Florida, prohibits any policy or procedure which results in discrimination on the basis of age, color, disability, gender identity, gender expression, national origin, marital status, race, religion, sex or sexual orientation. Individuals who wish to file a discrimination and/or harassment complaint may call the Director, Equal Educational Opportunities/ADA Compliance Department at 754-321-2150 or Teletype Machine TTY 754-321-2158.

Individuals with disabilities requesting accommodations under the Americans with Disabilities Act Amendments Act of 2008, (ADAAA) may call Equal Educational Opportunities/ADA Compliance Department at 754-321-2150 or Teletype Machine (TTY) 754-321-2158.



INSERT TITLE