

ST. MARY ACADEMY BAY VIEW

Rhode Island State law requires annual school year screenings of students based on grade level. Under State law parents wishing to have their child exempted from school based screenings must provide...satisfactory evidence that the same examination, or series of tests, as provided for by state regulation, has been completed within the preceding six (6) months by the student's health care provider(s). By completing the form below, health care professionals providing the required screening are certifying that the exams comply to state requirements and will exempt the student from school screenings.

STUDENT NAME: _____ GRADE _____

Date of Birth: _____ Parent Signature: _____

VISION (All Elementary students, 7th and 9th)

FUNCTIONS TESTED: Distance Visual Acuity, Near Visual Acuity, Ocular Alignment and for kindergarten students – color vision.

As the eye care professional for the above noted student, I certify that this student has undergone an eye exam that meets the State vision screening requirements.

DATE of EXAM: _____

RESULTS: VISION W/O GLASSES: Myopia R _____ L _____ Hyperopia R _____ L _____ Binocular _____

VISION W/ GLASSES: Myopia R _____ L _____ Hyperopia R _____ L _____ Binocular _____

Signature of Professional Eye Care Provider _____

Date _____

DENTAL (Grades Pre-K to 5 & 7)

CONDITIONS SCREENED : Soft tissue, Gross orthodontics and Dentition

As the private dentist for the above noted student, I certify that this student has undergone a dental exam that meets the State dental screening requirements.

DATE OF EXAM: _____

Signature of Dentist _____

Date _____

HEARING (Pre-K, K, 1,2 & 3)

SCREENING CRITERIA: Pure-tone screening, Immittance screening and Otoacoustic Emissions

I certify that the above noted student has undergone a hearing screening that meets the State hearing screening requirements.

DATE of EXAM: _____

RESULTS: IMPEDANCE (Tymp) R _____ L _____ PURETONE (Audio) R _____ L _____

Signature of Health Professional administering test _____

Date _____

SCOLIOSIS (Grades 6, 7 and 8)

DATE of EXAM: _____ RESULTS: _____

Signature and title of Exam Provider _____

Date _____