Home School Medical Screenings

School Year **2021-2022**

Name: _____ **Grade:** _____

Growth Screening (Annually)

Height:	**Weight:**
Date: _____	BMI % _____

Vision (Annually) Examination must be conducted by Vision Specialist (optometrist/ophthalmologist)

	Right	Left
Far		
Near		

Grade 1 or 2 or Upon Entry	
Plus Lens	
Color Vision	
Depth Perception (random E)	

Date: _____

Physician's Signature: _____

Hearing (Grades K, 1, 2,3, 7 & 11)

Right: _____ Left: _____

Date: _____

Physician's Signature: _____

Dental (required upon entry into school and grades 3 & 7)

Date: _____

Physician's Signature: _____

Scoliosis (grades 6 & 7)

Date: _____

Physician's Signature: _____

Physical (required upon entry into school and grades 6 & 11)

Date: _____

Physician's Signature: _____

Please attach immunization record or sign below:

I object to **immunizations** for my Child on religious grounds or on the basis of strong moral or ethical conviction similar to a religious belief:

_____ Date: _____

Parent's Signature

I object to ***Medical and/or Dental Screening*** due to a Religious belief

_____ Date: _____

Parent's Signature