School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

Kindergarten Health Screening Form

Student Name ______________________________ DOB________________ Date _______________________

School _______________ Gender M F (circle one) Grade_____ Teacher_____________________

HEARING Audiometric screening at 25db

Pass **Refer**

	4000HZ	2000HZ	1000HZ
R	____	_____	_____
L	____	_____	_____

Mark a ✓ to indicate student can hear sound at that level HZ

Mark an 0 to indicate student cannot hear sound at that level HZ

VISION (Pediavision Screener)

Pass **Refer**

____ Screened with glasses/contacts

____ Glasses not with student

School Use Only

Parent Notification 1st________________________ 2nd ___________________________ 3rd_____________________

Revised 03/16/2020

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First Health Screening Form

Student Name ______________________________ DOB________________ Date ______________________

School _______________ Gender M F (circle one) Grade_____ Teacher_____________________

HEARING Audiometric screening at 25db

Pass **Refer**

4000HZ 2000HZ 1000HZ

R ____ _____ _____
L ____ _____ _____

Mark a ✓ to indicate student can hear sound at that level HZ
Mark an 0 to indicate student cannot hear sound at that level HZ

VISION (Pediavision Screener)

Pass **Refer**

____ Screened with glasses/contacts
____ Glasses not with student
____ Unable to Screen

Body Mass Index (BMI)

Your child's results: Ht.________inches Wt.________pounds BMI______ Percentile______ R_____

BMI for Age Percentile	What it means	Recommendations
Less than 5%	Underweight	Medical Assessment
5% to 84%	Normal/healthy	No action needed
85% to 94%	At risk of overweight	Medical Assessment if other Risk factors
95% and greater	Overweight	Medical Assessment

School Use Only
Parent Notification 1st_____________________ 2nd _______________________ 3rd__________________

Revised 03/16/2020

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Second Grade Health Screening Form

Non-Mandated

Student Name ______________________________ DOB________________ Date _______________________

School _______________ Gender M F (circle one) Grade______ Teacher_____________________

VISION (Pediavision Screener)

Pass **Refer**

____ Screened with glasses/contacts
____ Glasses not with student
____ Unable to screen

School Use Only
Parent Notification 1st_________________________ 2nd _____________________________ 3rd______________________

Revised 03/16/2020

School District of Indian River County

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Third Grade Health Screening Form

Student Name ______________________________ DOB________________ Date ______________________

School _______________ Gender M F (circle one) Grade______ Teacher_____________________

HEARING Audiometric screening at 25db

Pass **Refer**

4000HZ 2000HZ 1000HZ

R ____ _____ _____
L ____ _____ _____

Mark a ✓ to indicate student can hear sound at that level HZ
Mark an 0 to indicate student cannot hear sound at that level HZ

VISION (Pediavision Screener)

Pass **Refer**

____ Screened with glasses/contacts
____ Glasses not with student
____ Unable to Screen

Body Mass Index (BMI)

Your child's results: Ht.________inches Wt.________pounds BMI______ Percentile______ R_____

BMI for Age Percentile	What it means	Recommendations
Less than 5%	Underweight	Medical Assessment
5% to 84%	Normal/healthy	No action needed
85% to 94%	At risk of overweight	Medical Assessment if other Risk factors
95% and greater	Overweight	Medical Assessment

School Use Only
Parent Notification 1st_____________________ 2nd _______________________ 3rd__________________

Revised 03/16/2020

School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

Sixth Grade Health Screening Form

Student Name ______________________________ DOB________________ Date ________________________

School _______________ Gender M F (circle one) Grade______ Teacher______________________

HEARING Audiometric screening at 25db

Pass **Refer**

4000HZ 2000HZ 1000HZ

R ____ _____ _____
L ____ _____ _____

VISION (Pediavision Screener)

Pass **Refer**

____ Screened with glasses/contacts
____ Glasses not with student
____ Unable to Screen

Mark a ✓ to indicate student can hear sound at that level HZ
Mark an 0 to indicate student cannot hear sound at that level HZ

Body Mass Index (BMI)

Your child's results: Ht._________inches Wt._________pounds BMI______ Percentile______ R_____

BMI for Age Percentile	What it means	Recommendations
Less than 5%	Underweight	Medical Assessment
5% to 84%	Normal/healthy	No action needed
85% to 94%	At risk of overweight	Medical Assessment if other Risk factors
95% and greater	Overweight	Medical Assessment

SCOLIOSIS (6th grade students only) **Pass** **Rescreen**

Referred ________degree Scoliometer Reading

Scoliometer reading of seven degrees or more-Refer

School Use Only
Parent Notification 1st______________________ 2nd ______________________ 3rd ______________________

Revised 03/16/2020

School District of Indian River County

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Health Screening Form

Student Name ______________________________ DOB________________ Date _______________________

School _______________ Gender M F (circle one) Grade______ Teacher_____________________

HEARING Audiometric screening at 25db

Pass **Refer**

4000HZ 2000HZ 1000HZ

R ____ _____ _____

L ____ _____ _____

Mark a ✓ to indicate student can hear sound at that level HZ

Mark an 0 to indicate student cannot hear sound at that level HZ

VISION (Pediavision Screener)

Pass **Refer**

____ Screened with glasses/contacts

____ Glasses not with student

____ Unable to screen

Body Mass Index (BMI)

Your child's results: Ht.__________inches Wt.__________pounds BMI______ Percentile______ R_____

BMI for Age Percentile	What it means	Recommendations
Less than 5%	Underweight	Medical Assessment
5% to 84%	Normal/healthy	No action needed
85% to 94%	At risk of overweight	Medical Assessment if other Risk factors
95% and greater	Overweight	Medical Assessment

SCOLIOSIS (6th grade students only) **Pass** **Rescreen**

Referred ________degree Scoliometer Reading

Scoliometer reading of seven degrees or more-Refer

School Use Only

Parent Notification 1st_________________________ 2nd ____________________________ 3rd______________________

Revised 03/16/2020

School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

Ninth Grade Non-Mandated Health Screening Form

Student Name ______________________________ DOB________________ Date ________________________

School _______________ Gender M F (circle one) Grade______ Teacher______________________

HEARING Audiometric screening at 25db

Pass **Refer**

	4000HZ	2000HZ	1000HZ
R	____	_____	_____
L	____	_____	_____

Mark a ✓ to indicate student can hear sound at that level HZ

Mark an 0 to indicate student cannot hear sound at that level HZ

VISION (Pediavision Screener)

Pass **Refer**

____ Screened with glasses/contacts

____ Glasses not with student

School Use Only

Parent Notification 1st______________________ 2nd _________________________ 3rd____________________

School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

Re: Non-Mandated Screening
From: Office of Health Services
To: Parent/Guardian

This is to inform you of a vision and/or hearing screening that we will be conducting at your child's school. Please sign below indicating that you are giving permission to have your child screened outside of the mandated grades. If your child needs a further evaluation/referral after the screenings are complete, you will be notified.

Thank you,

Health Services

Student name:_____________________________ Student ID:____________________________

Parent/Guardian Print Name:____

Parent Signature:____

Teacher:_______________________________

Re: Examen no obligatorio
Desde: Oficina de Servicios de Salud
Para: Padre/Tutor

Esto es para informarle de la visión y /o la detección auditiva que llevaremos a cabo en la escuela de su hijo. Por favor, firme a continuación indicando que está dando permiso para que su hijo se haga una prueba fuera de las calificaciones exigidas. Si su hijo necesita una evaluación/referencia adicional después de que se completen las pruebas de detección, se le notificará.

Gracias

Servicios de salud

Nombre del estudiante:___________________________ Identificación del estudiante:________________

Nombre de impresión del padre/tutor:____

Firma de padre:____

Profesor:_________________________________

Revised 02/06/2020

In School Dental Sealant Program

Treasure Coast Community Health, Inc.

Location: Indian River Academy **Date:** April 21, 2022

Dear Parent/Guardian,

Your child, ______________________________________, participated in Treasure Coast Community Health's Sealant Program.

____ Sealant(s) were placed on ___/ 4 permanent molars.
____ Fluoride was applied to all teeth.
Note: Sealants are not placed on teeth that are still erupting (growing out of the gum), or have possible cavities.

A complete dental exam with X-rays was not done today, only a dental screening.

Based on our findings, however, it is recommended that your child see a Dentist for:

☐ 3) Emergency Dental Treatment – Immediately!

☐ 2) Possible treatment of dental cavities – as soon as possible.

☐ 1) A regular dental exam with X-rays and a cleaning every 6 months.

To make an appointment with a TCCH Dentist, or if you have any further questions, please call our office at (772) 257-8224. We have dental offices, medical care, behavioral healthcare, pharmacy services, and more, located in Indian River County. We accept Medicaid, and most other types of insurances. We also offer an income-based Sliding Fee Scale (SFS) program.

We want to be involved in your child's healthy future.

PERMISSION FORM

Treasure Coast Community Health

Dental Program

______________ (School)

______________ (Teacher & Grade)

Please complete ALL sections of this form in PEN

Child's Name ____ Date of Birth _____________ Sex ☐ M ☐ F

LAST First Middle mm/dd/yyyy

Street Address ____________________________ City:__________________ ZIP Code_______

Race ☐White ☐Black/African American ☐American Native/Alaskan Native ☐Asian ☐Hawaiian Native/Pacific ☐Islander Ethnicity ☐Hispanic ☐Non-Hispanic Primary Language ______________________

Name of Dental Insurance______________________________ ID #________________________________

Child's Health History:

☐ Yes ☐ No Has your child seen a dentist within the last year?
If yes, dentist's name:______________________________________

☐ Yes ☐ No Does your child have any medical conditions?
If yes, please list:______________________________________

☐ Yes ☐ No Is your child allergic to anything?
If yes, please list:______________________________________

☐ Yes ☐ No Is your child taking any medications?
If yes, please list:______________________________________

By signing this form, I give permission for my child to participate in this preventive dental program that will take place at his or her school.

☐ Mother ☐ Father ☐ Legal Guardian

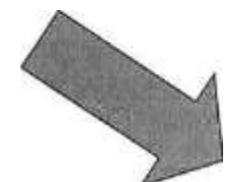
Parent/Legal Guardian Name (Printed):____

Signature:____ Date:__________________

Telephone: Home _______________________________ Cell ___________________________

TURN PAGE OVER

THE NEXT PAGE MUST BE COMPLETED



INITIATION OF SERVICES

PART I. CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name (Child's Name):________________________________

Name of Agency: Treasure Coast Community Health

Agency Address: 1955 21st Ave Vero Beach, Florida 32960

I consent to entering into a client-provider relationship. I authorize **Treasure Coast Community Health** staff and their representatives to render routine health care. I understand routine health care is confidential and voluntarily and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II. DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)
I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations

PART III. COMMUNICATIONS
I understand the Treasure Coast Community Health uses a patient portal to communicate with me about my health care. In order to receive electronic communications about my health care, I need to provide my email address to the department and then, I will be contacted by email to create a portal account.
I understand that I must agree to the terms and conditions of use associated with the portal when I create my account. I understand that the portal is password protected and that I am responsible for maintaining the confidentiality of my username and password and for all activities that are conducted through my portal account. I understand that I will receive emails letting me know that TCCH has sent information to the portal.
_____Initial here to authorize and give my express consent to the TCCH to make your health care information available to you through the portal. Email Address: ________________________________

PART IV. ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)
As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER
(This notice is provided pursuant to Section 119.071 (5)(a), Florida Statutes.)
For health care programs, Treasure Coast Community Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071 (5)(a)2.a. and 119.071 (5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Treasure Coast Community Health is imperative for the performance of duties and responsibilities as prescribed by law.

Part VI PHOTOGRAPH
Yes _____ , I hereby grant TCCH permission to photograph and to use my child's likeness in a photo graph in any and all of its publications , including website entries , without payment or any other considerations.
No _____, My child cannot be photographed during his/her participation at screening day

PART VI MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

________________________________ ________________________________ ______________
Client/Representative (Parent/Legal Guardian) Signature | Self or Representative's Relationship to | Date

________________________________ ______________
Witness (optional) | Date