



School Health Screening Handbook

Provided by:



In collaboration with:



MDPH School Health Services

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Important Notes

About this Handbook

The materials in this handbook summarize the key information school nurses need to plan and conduct mandated health screenings of school-aged children in Massachusetts. It is intended to be used as a quick reference *only*. Massachusetts school nurses are responsible for knowing the full statutes, regulations, and guidelines for all health screenings.

Sample Documents and Additional Resources

There is a section dedicated to school health screenings on the [SHIELD Health Screenings webpage](#). Links to sample screening letters and documents, regulatory guidance, and additional resources can be found there.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a separate training and is not included in this manual. Instruction and guidance for conducting SBIRT can be found on the [MASBIRT TTA webpage](#).

Data Reporting

Massachusetts Department of Public Health (MDPH) requires schools to submit reports on some screening data.

Acknowledgement

This handbook depicts MA health screening laws, and related regulations and guidance from MDPH. It was reviewed by MDPH and MA Regional School Nurse Consultants (Shanyn Toulouse, Mary Jane O'Brien, Ann Linehan, Veronica Webb Barret, Jill Connolly, Tracy Rowe & Margaret Burch). Shanyn Toulouse also contributed to the checklist found in this handbook.

Laws & Regulations

[MGL Ch71, s57](#) : Physical examination of pupils; eye examination, written report, and related regulations (105 CMR 200.000) require physical examinations of schoolchildren within 12 months before entry into school or within 30 days after school entry, at intervals of either three or four years thereafter, and on an annual basis prior to a student's participation in competitive athletics. It is the responsibility of the school committee or LBOH to designate these intervals.

The regulations require physical examinations for:

- (1) children referred because of frequent absences due to unexplained illness;
- (2) children referred because of known physical defects that require repeated appraisal;
- (3) children referred from a teacher-nurse conference because the child is not making expected progress in school or because of signs of illness noted by the teacher or nurse;
- (4) children under 16 and over 14 years of age requesting employment certificates; and
- (5) children planning to participate in competitive athletics annually.

The school health program should expect that the physical examination and ongoing health assessments will be performed by the family's own primary care provider. If a child does not have a primary care provider, every effort should be made to link them with a primary care provider in the community. The school committee or board of health is required to provide the services of a school physician to carry out physical examinations, in hardship cases for children who do not have access to a private primary care provider (MGL Ch71, s53 and s57).

MDPH is the administrative authority to determine screening implementation requirements. MDPH has the discretionary power to waive certain requirements for population-based screenings upon written request by school districts. There is a screening program waiver process for vision, hearing, and growth screenings, valid for one year after an application is approved.

Per MGL Ch71, s57, in the absence of a religious exemption, all public school children must be screened according to the schedule outlined in the statutes. Parents/guardians of children in non-public schools may also request these screenings.

Screenings must be conducted by MDPH-approved personnel. School nurses and those who have had required specialized training approved by MDPH may also perform the screenings.

[105 CMR 200.000](#): Physical Examination of School Children provides regulatory guidance on conducting health screenings including physical exams, vision and hearing screening, and height and weight measurements. These regulations define when each type of screening must be done, who may perform screenings, screening exemptions, and describe referral and record keeping requirements. Note that these regulations may change from time to time to reflect best practices or revisions in the law.

The [Comprehensive School Health Manual](#) is not a regulation, but the screening information outlined in Chapter 5 should be used as a resource and followed as MDPH guidance.

Screening Guidelines by Grade

Grade*	Vision			Hearing Pure Tones	Ht, Wt, BMI Stadiometer & Scales	Postural Visual Assessment	SBIRT**** CRAFFT+N
	Distance Acuity	Near Acuity	Stereopsis				
	Monocular R & L	Binocular	Binocular				
PreK	X	X					
K**	X	X	X	X			
1st	X	X	X	X	X		
2nd	X	X	X	X			
3rd	X	X	X	X			
4th	X				X		
5th	X					X	
6th***	6, 7, or 8			6, 7, or 8		X	6, 7, or 8
7th	6, 7, or 8			6, 7, or 8	X	X	6, 7, or 8
8th	6, 7, or 8			6, 7, or 8		X	6, 7, or 8
9th**	9, 10, 11 or 12			9, 10, 11 or 12		X	9, 10, 11 or 12
10th	9, 10, 11 or 12			9, 10, 11 or 12	X		9, 10, 11 or 12
11th	9, 10, 11 or 12			9, 10, 11 or 12			9, 10, 11 or 12
12th	9, 10, 11 or 12			9, 10, 11 or 12			9, 10, 11 or 12

Per MGL Ch71, s57, students diagnosed with neurodevelopmental delay should be referred for a comprehensive eye exam from an eye doctor, if they have not presented the school with proof of such upon school entry.

*For schools with ungraded classes, refer to 105 CMR 200.400 for specific age ranges for vision and hearing, screening, and 105 CMR 200.500 for height, weight, and BMI measurements.

** K students must also be screened for vision within the first 30 day of entry if the parent or guardian does not present certification that they have passed a vision screening within the previous 12 months.

*** School nurses must conduct vision & hearing screenings in at least one grade from 6th to 8th, and in at least one grade from 9th to 12th. SBIRT screening is done once in a Middle School grad and once in a High School grade.

****For details, refer to the SBIRT in Schools Resource Toolkit found in the MASBIRT TTA webpage.

Screening Checklist

Date Completed: [Click or tap here to enter text.](#)

INVENTORY EQUIPMENT & SUPPLIES

BMI

☐ CDC BMI calculator saved on my computer, or in my electronic health record system

List which option: [Click or tap here to enter text.](#)

☐ Stadiometer (measurable to nearest 1/8" or cm)

☐ Stadiometer mounted at proper wall height

☐ Scale that can be zeroed (calibrated at least annually)

Date last calibrated: [Click or tap here to enter text.](#)

Hearing

☐ Correctly functioning audiometer(s)

☐ # of machines: [Click or tap here to enter text.](#)

☐ Type/model of each, and date last calibrated:
[Click or tap here to enter text.](#)

Postural

☐ Tape mark on level floor

☐ Changing area or halter tops available

☐ Screening area with separate entrance/exit, and enough space for screener to move freely around student for front, back, and side views

Vision

All visual acuity charts must use logMAR notation/scoring, and use LEA SYMBOLS or Sloan Letters. For further information on screening tools see the [Vision Screening Section starting on page 21](#) of this Screening Handbook. When purchasing new vision tools, see [SHIELD's Health Screenings webpage](#) for a detailed list of equipment, including model numbers.

☐ Distance Vision:

Type: [Click or tap here to enter text.](#)

Properly fitted occluders

☐ Near Vision:

Type: [Click or tap here to enter text.](#)

☐ Stereoacuity:

Type: [Click or tap here to enter text.](#)

☐ Instrument-based screening machine (ages 3, 4, 5)

Schedule a loan of a Spot™ screening machine with your Regional School Nurse Consultant

RECRUIT & TRAIN SCREENING TEAM

☐ Screening team set for each type of screening
Names/dates they will be working: [Click or tap here to enter text.](#)

☐ Training planned:

Describe: [Click or tap here to enter text.](#)

SCHEDULING

Try to plan fall screening dates the prior spring.

☐ Clinic dates/times, space permissions, communication plan for teachers, administration, SPED, parents/guardians all established
Clinic dates/locations: [Click or tap here to enter text.](#)

☐ Class schedule reviewed, teachers identified in case of conflicts, and screening schedule developed

☐ Screening spaces identified, ensuring that they:
☐ Are properly sized, lit, and offer privacy

☐ Postural screening in-class training scheduled
Date(s): [Click or tap here to enter text.](#)

☐ Administration informed and approved of screening schedule and locations

☐ Schedule shared with teachers (revise if needed)

COMMUNICATIONS

☐ Parents/guardians notified of screenings
(See [SHIELD Health Screenings webpage](#) for sample letters and educational materials)
Dates/types of communication: [Click or tap here to enter text.](#)

☐ Educational materials included in parent/guardian communications (esp. promoting healthy weight/active living, and postural screening)

PREPARE FOR SCREENING DAY

☐ Postural screening in-class training completed

☐ Protocols for all screenings reviewed

☐ Blank referral letters for all screenings copied and ready to complete

- ☐ Screening lists have been prepared
- ☐ Availability of screening rooms confirmed
- ☐ Schedule confirmed with teachers (incorporating any needed last-minute adjustments)
- ☐ Signage posted (as needed)
- ☐ Screening spaces set up:
 - ☐ Functional equipment
 - ☐ Cheat sheets for vision & hearing machines
 - ☐ Floors marked
 - ☐ Privacy screens (where needed)
 - ☐ Student waiting area with activities (i.e., books)
- ☐ Screening team assigned to stations and briefed on the plan for the day

CONDUCT SCREENINGS

- ☐ Refer to screening protocols in this handbook

RE-SCREENING STUDENTS

- ☐ Review data collection sheets to identify students who need to be screened (i.e., absent/missing on original date), rescreened, and referred
- ☐ Re-screening dates and spaces confirmed
Dates/locations: [Click or tap here to enter text.](#)
- ☐ Re-screening team confirmed
[Click or tap here to enter text.](#)
- ☐ List of students to be re-screened or who missed the first screening date
- ☐ Teachers notified of re-screening dates and list of students to be screened
- ☐ Screening spaces set up

DOCUMENTATION & REFERRALS

Post-Screening Documentation

- ☐ Screening data documented in student's paper/electronic health record
- ☐ Teachers notified of required/recommended classroom accommodations

Referral Completion

- ☐ Referral letters sent to parents/guardians and documented in student's record
(See [SHIELD Health Screenings webpage](#) for sample letters and educational materials)
- ☐ Follow up on incomplete referrals (dates entered into calendar to do follow ups):
 - ☐ Second referral notice sent to parent (as needed)
 - ☐ Parent/guardian contacted directly (as needed)
 - ☐ Referral outcomes recorded in student record

REPORTING

- ☐ BMI and SBIRT results prepared to submit to MDPH
- ☐ *For CSHS grant recipients only:* All screening data prepared to submit to MDPH

POST-SCREENING PLANNING

- ☐ Appointments made to calibrate machines for next year:
 - ☐ Hearing (date & vendor): [Click or tap here to enter text.](#)
 - ☐ Scales (date & vendor): [Click or tap here to enter text.](#)
- ☐ Plan for repairing/replacing equipment (if needed):
[Click or tap here to enter text.](#)

REMINDERS FOR NEXT SCHOOL YEAR

[Click or tap here to enter text.](#)

Special Considerations

Students with Disabilities

While it is your responsibility to ensure all students are screened, you will be unable to successfully screen some students with disabilities. For these students, be sure you have physician documentation on file that shows these children have been evaluated within the required screening period. If you do not have such documentation on file, send home a referral and ensure that the evaluation is completed.

Some students with disabilities may be able to participate successfully in the screenings with assistance from a teaching assistant or special education teacher. However, care should be taken to ensure teachers are not providing students with answers (i.e., guiding their hand to an answer). In other cases, students with disabilities may not be able to be successfully screened, but they should still be included in the screening process with their class. Inclusion is important, and some students may be able to learn skills, like how to use headphones.

For all students with disabilities, collaborate with the special education team to determine how each student will participate in the screening process. Regardless of the level of participation, students you are unable to screen with confidence must be referred unless you have current documentation on file indicating that a physician evaluation has been completed for the applicable screening period.

Additionally, the state also requires proof of a comprehensive eye examination, performed by a licensed optometrist or ophthalmologist, for children diagnosed with neurodevelopmental delay within 12 months prior to entering Kindergarten ([MGL Ch17, s57](#)). Although the term “neurodevelopmental delay” may be subject to interpretation, it is likely to include children born prior to term, children with low birth weights, and children with neurological disorders as evidenced by cerebral palsy, Down Syndrome, multiple handicaps, hearing impairment, speech/language delay, ADHD, or developmental delay.

Homeless Students

Homeless students present special concerns in the context of screening programs. Frequent moves often make these students unable or unavailable to participate in screenings, and, in the event screenings are completed, these students may need special assistance with referrals and follow-up, including help with making appointments and with transportation to providers’ offices. The district’s homeless education liaison, who is the staff person designated to help homeless children and youth, should be consulted in these instances. The Department of Education (DOE) maintains a list of district-level homeless liaisons, which can be found on their [website](#).

BMI Screening

BMI Screening Equipment and Tools

When measuring weight, use a properly calibrated balance-beam or strain-gauge floor scale (digital or mechanical) that:

- Registers weight in 0.1 kilogram or 1/4 pound increments
- Has a stable platform
- Can be zeroed out between students
- Can be calibrated



When measuring height, use a stadiometer that:

- Registers height to 0.1 centimeter or 1/8 inch
- Has a stable base
- Has a horizontal headpiece at least 3 inches wide that can be brought into contact with the most superior part of the head, typically the crown (NOTE: movable headpieces attached to balance-beam scales are not recommended for use)



To ensure an accurate BMI calculation:

- If using inches for height, use pounds for weight
- If using centimeters for height, use kilograms for weight

Maintenance and Calibration of Equipment

Scales should be calibrated on a routine basis.

- Re-calibrate if the scale has been moved to a different surface
- Portable digital scales that are frequently moved should be calibrated monthly
- Scales that are not moved or used excessively should be calibrated annually by contacting the local department of weights and measures

Check the equipment regularly (i.e., the stability of the stadiometer base) to ensure accurate measurements.

BMI Screening Protocols

Screening Tips

- Be careful of word choice. Students may be sensitive about their height or weight. Avoid language like “Let’s see how big you are,” and labels such as obese or too thin.
- Avoid common mistakes:
 - Make sure measurements are taken with student’s shoes off
 - Be consistent with measurements (use inches *or* centimeters, don’t mix the two)
 - Measure carefully and correctly when installing wall stadiometers
 - Ensure scales are calibrated
- To improve accuracy, MDPH recommends that at least two staff conduct the BMI screening: one to measure the child and one to record the data. This greatly reduces recording errors.

Protocols for Measuring Weight

To accurately measure students’ weight, the following procedures should be followed:

- Ensure the scale is on a firm surface, preferably on an uncarpeted floor.
- Set the scale to a zero reading.
- Have student remove their shoes, accessories, and heavy outer clothing (i.e., sweater, jacket, vest, belt).
- Have student empty their pockets of heavy objects (i.e., cell phones, electronics).
- Have student step onto the scale platform with both feet, facing away from the scale.
- Ask student to remain still.
- Read weight to the nearest 1/4 pound or 0.1 kilogram.
- Record weight immediately on the data form before the student gets off the scale.
- If using a balance-beam scale, return weights to zero position.

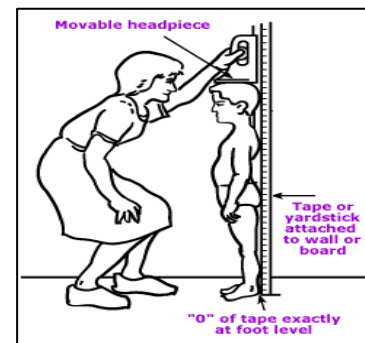
Assessing the weight of non-ambulatory students with special health care needs requires special consideration as children may not be able to stand up or lie flat. Alternate methods are available for measuring children requiring special accommodations. More detailed information on measuring non-ambulatory students can be found at the end of this section.

Protocols for Measuring Height

To accurately measure students’ height, the following procedures should be followed:

- Have student remove their shoes.
- Have student remove hat and/or hair ornaments, and undo buns and braids to the greatest extent possible (rather than guessing, note on their chart if you’re unable to obtain an exact measurement).

- Have student step onto the base, with their back against the stadiometer rule.
- Student should stand with legs together (in contact with each other at some point).
- Check student's posture – head in appropriate position, knees not bent, arms at their sides, and shoulders relaxed.
- Make sure the student's body is in a straight line (mid-axillary line parallel to the stadiometer).
- Ensure some point of the back of the student's body is in contact with the stadiometer.
- Lower headpiece snugly to the crown of the student's head with sufficient pressure to flatten hair.
- Read height at eye level in an upward direction (from lower to higher number).
- Record height to the nearest 0.1 centimeter or 1/8 inch onto the data form.
- Repeat the process, having the student line up again, and record the measurement again.
- If the second measurement does not agree with the first measurement within 0.5 centimeter or 1/4 inch, repeat the process a third time.



Assessing the height of non-ambulatory students with special health care needs requires special consideration as children may not be able to stand up or lie flat. Alternate methods are available for measuring children requiring special accommodations. More detailed information on measuring non-ambulatory students can be found in the next section.

Protocols for Measuring Non-Ambulatory Students

Assessing growth status of students with genetic or other medical conditions requires special consideration. In the event that it is necessary to collect height and weight information in the school setting, be sure that the screening is conducted by a health care professional (i.e., school nurse, occupational therapist, physical therapist). In addition, be sure parents or legal guardians are also informed in advance of the screening.

In general, the purpose of measuring students who may have atypical growth patterns should be for monitoring the progress of that individual student over time, not used to compare that student to others, even those who may have a similar condition. Remember that BMI is used to indicate measures of body fatness. For some conditions that involve muscle deterioration and/or abnormal bone growth, the standard BMI reference percentile curves would not be an appropriate comparison point.

Assessing Weight of Non-Ambulatory Students

Possible options for assessing weight for students who cannot stand include:

- Using a bucket seat scale if student is within size and weight limits for the equipment
- Using a chair scale
- Using a bed scale
- Using a platform scale that can accommodate a wheelchair (subtract the weight of the wheelchair)
- A caregiver holding the student on the scale (subtract the caregiver's weight)

In any of the above cases, make note of the procedure used to obtain weight, as there is a higher potential for error.

Assessing Stature/Length of Non-Ambulatory Students

For students who are unable to stand, but are generally typical in body development and growth, their recumbent length can be taken as follows:

- Two people are needed
- One person (parent/caretaker) holds student's crown of head against the headboard
- Check that the student's head position is in Frankfort plane
- Student's trunk and pelvis should be aligned straight along measuring board
- Second person straightens the student's legs and holds their ankles together with toes pointed directly upwards
- Move the footboard firmly against the soles of both of the student's feet
- Record measurement to the nearest 1/8 inch or 0.1 centimeter
- Repeat measurement until two of them agree within 1/4 inch or 0.5 centimeter

For students with typical development, but who are unable to stand, arm span can be measured. When accurately measured, the arm span to height ratio is about 1:1 with typical development.

- This method is appropriate for students older than age 5, with involvement of the lower body only (i.e., some students with myelomeningocele or lower body paralysis)
- Arm span measuring requires two people
- The student should extend both arms perpendicularly to the body while the measuring rod (i.e., anthropometer) is held across the back, extended from the tip of the middle finger of the right hand to the tip of the middle finger of the left hand
- Repeat measurement
- Measurement can be plotted on the CDC charts for stature-for-age or length-for-age



For students who are unable to stand and/or have severe contractures, their sitting height can be measured as follows:

- Use a stadiometer and surface for sitting (typically 50cm x 40cm x 30cm) that can be rotated depending on the size of the student
- Have the student sit on the base as erectly as possible with buttocks (and back and shoulder blades if possible) in contact with the stadiometer board
- Student should let their legs hang freely, with hands on their thighs and knees pointed straight ahead
- Student's head should be positioned in Frankfort plane
- Repeat measurement until two of them agree within 1/4 inch or 0.5 centimeter
- After taking the measurement, subtract the height of the sitting surface to estimate the student's sitting height
- Measurements may be plotted to establish student's individual growth pattern over time

Growth of students for whom stature measurements are impossible to take can be monitored by using segmental lengths (i.e., upper arm length, lower leg length).

Measuring upper arm length is recommended for students with spina bifida who are bedridden or wheelchair bound, or for other students who are unable to stand or stretch out on a length board. When measuring upper arm length:

- Keep the student's upper arm straight and positioned alongside the body
- Have student bend their elbow so their lower arm is at a 90-degree angle to their upper arm
- Place a flexible metal or sturdy plastic tape measure with the tip at the end point of the shoulder bone, and bring the tape straight down along the upper arm to the tip of the elbow
- Record measurement to the nearest 1/8 inch or 0.1 centimeter
- Repeat measurement until two of them agree within 1/4 inch or 0.5 centimeter

Students with cerebral palsy or other conditions that cause or result in contractures can have their lower leg length measured.

- Use either a steel or plastic tape measure or an anthropometer
- Lower leg measurements are difficult to take
- Lower leg length measurements should only be used for students aged 6-18 years old
- Measurements may be plotted on the CDC charts for stature-for-age or length-for-age to establish the student's individual growth pattern over time

BMI Screening Referral and Follow-Up

The school nurse is in an ideal position to ensure the early identification of children at risk for growth problems by providing appropriate assessments and referrals.

Children should be referred for further assessment when:

- weight-for-height or weight-for-age is above the 95th percentile
- weight-for-height, weight-for-age, or height-for-age is below the 5th percentile
- BMI-for-age is below the 5th percentile or above the 85th percentile
- the student's growth pattern changes dramatically (i.e., student who has been consistently at the 50th percentile drops to the 10th or rises to the 90th)

For BMI screening results that are significantly out of range or of particular concern, it may be appropriate for the school nurse to contact the student's parents or legal guardians and encourage follow-up with the child's primary care provider. It is important to note that BMI does not differentiate between fat tissue and lean tissue (for example, an athlete who has more muscle may have a higher-than-expected BMI for his/her height, weight). Any concerns should be discussed by the parents/legal guardians with their child's primary care provider.

BMI Documentation and Reporting

The student's growth chart, including screening results, referrals, and follow-ups, should be part of their school health record.

Report aggregate data at the end of the school year to MDPH.

To ensure data quality and reliability, guidelines for checking for quality issues with data before reporting are available:

For Grade 1:

- if more than 1% of recorded heights are below 40 inches or over 55 inches
- if more than 1% of recorded weights are below 37 pounds or over 110 pounds

For Grade 4:

- if more than 1% of recorded heights are below 48 inches or over 63 inches
- if more than 1% of recorded weights are below 51 pounds or over 180 pounds

For Grade 7:

- if more than 1% of recorded heights are below 54 inches or over 71 inches
- if more than 1% of recorded weights are below 70 pounds or over 260 pounds

For Grade 10:

- if more than 1% of recorded heights are below 57 inches or over 74 inches
- if more than 1% of recorded weights are below 74 pounds or over 275 pounds

Hearing Screening

Hearing Screening Equipment and Tools

The audiometer used in school-based hearing screening programs must meet the standards for screening audiometers established by the American National Standards Institute (ANSI). It must have air conduction frequencies of 1000, 2000, and 4000 Hz.

Maintenance and Calibration of Equipment

Screening audiometers are quite fragile, so proper handling and transport are essential to ensure accurate readings from a properly calibrated machine. MDPH notes that, since all audiometers drift out of calibration with regular use, it is very important that each audiometer receive a full laboratory calibration by an external company at least once a year. The American Speech-Language-Hearing Association (ASHA) and the Occupational Safety and Health Administration (OSHA) recommend calibration as an important component for accurate hearing screening results.

Hearing Screening Protocols

Screening Tips

- Audiometers are sensitive machines that need to be calibrated annually.
- Colds and ear infections may interfere with hearing, so try to complete your hearing screenings by early November before cold and flu season begins.
- Create as quiet a space for hearing screenings as possible. Background noise and distractions may lead to a high rate of students who need to be rescreened.
- Clean the headset according to the manufacturer's guideline.
- A note on lice: Follow your school nurse headlice procedures and district headlice protocol.

Protocols for Measuring Hearing using Pure Tone Audiometer

Signals:

The signal type to be used is the individual pure tone test only. Pure tone testing frequencies are 1000, 2000, and 4000 Hz and the pure tone screening level is 20dB across all three frequencies.

Test administration

A passing screen is when the child identifies 20dB at 1000, 2000, and 4000 Hz. If a child does not pass at these levels, schedule a rescreening within one week and no later than two weeks after the original test.

To accurately measure students' hearing, the following procedures should be followed:

- Plug in and turn on audiometer 10 minutes before beginning the screening.
- Seat student at a 90-degree angle from the screener and audiometer.
- Put headphones on student with the RED earpiece on the RIGHT ear.
- Adjust headband.
- Instruct student to raise their hand when he/she hears the sound/beep/tone, and to put that hand down when that noise stops.
- Beginning with the RIGHT ear:
 - 1,000 Hz at 50 dB
 - 1,000 Hz at 30 dB
 - 1,000 Hz at 20 dB
 - 2,000 Hz at 20 dB
 - 4,000 Hz at 20 dB
- Switch to LEFT ear:
 - 4,000 Hz at 20 dB
 - 2,000 Hz at 20 dB
 - 1,000 Hz at 20 dB
- NOTE:
 - If at any frequency (Hz) level, the student does not hear the sound, increase the decibel level (loudness) by 10 and repeat the process until he/she hears the tone.
 - Document that finding (i.e., 2,000 Hz at 40 dB)
 - Any finding that does not reach the objective of 20 dB suggests the need to retest at a later date or make a referral.

Hearing Screening Referral and Follow-Up

Regulations developed under the Comprehensive Special Education Law, c.766 p.306, 1(D), specify that, beginning with the third birthday, children with special needs or children suspected to have a hearing problem by their parent/guardian must be given a test for auditory functioning appropriate to the child's age and developmental stage.

Appropriate medical and audiological follow-up and referrals are central to an effective system. In general, all children who fail the initial screening should be retested within 1-2 weeks before being considered a candidate for a notice to the parent/guardian. A repeat failure of the screening justifies parental notification in writing. Children should be referred for further assessment when they are unable to identify 20dB at 1000, 2000, or 4000 Hz upon rescreening. The typical failure rate in a screened population is approximately 2½-3%. If the findings of the hearing screening vary significantly from this (either consistently higher or lower), a review should include, at a minimum, the skill of the tester, the appropriateness of the testing site (i.e., presence of ambient noise), the condition of the audiometer, and an evaluation of the testing procedures. Screening tests are not diagnostic; they merely identify students who may need further attention by a primary care provider or audiologist.

Hearing Documentation and Reporting

All hearing screening results (passes and referrals) should be recorded on the student's school health record.

In the event that parental notification is required, the school health staff should make every attempt to follow up to determine:

- (1) that the parent/guardian consulted the primary care provider
- (2) whether a resolution of the apparent hearing problem was made, and
- (3) whether any educational adjustments were made

Report aggregate data to MDPH for CSHS grant recipients.

Postural Screening

Postural Screening Equipment and Tools

No equipment is needed for the postural screening.

Parents/guardians should be notified prior to the screening, consistent with MDPH recommendations. This notification should include the date of the screening, the reason for it, statutory requirements, and proper clothing recommendations. Additional educational materials, such as the postural screening brochure, may also be included (see the [SHIELD Health Screenings webpage](#) for sample letters and educational materials).

Postural Screening Protocols

Screening Tips

- Take care to ensure student privacy during the screening process, being sensitive to body image and gender identity
- Have a second staff member present
- Remind students to remove their shoes
- Send a reminder notice home a few days before the screening recommending girls wear halter or bathing suit tops and that boys will need to remove their shirt

Family and Student Education:

Prior to conducting postural screening, parents/guardians and students should be provided with educational materials. Use your district's typical system for communicating with parents to inform them about the screening.

Schedule an in-class student education session shortly before the screening is to be done. This session should be taught by someone who has medical knowledge and should include the following information:

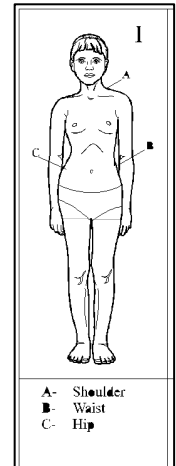
1. When, where, and how the screening will be done
2. What you will be looking for
3. Special clothes that need to be worn
4. Short discussion of postural problems (i.e., Scoliosis, Kyphosis, Lordosis)
5. A question and answer period

The National Scoliosis Foundation has an educational video that can be shown to students. Educational resources, including a link to the video, FAQ on the postural screening, a parent letter, and an informational brochure, can be found on the [SHIELD Health Screenings webpage](#).

Protocols for Measuring Posture

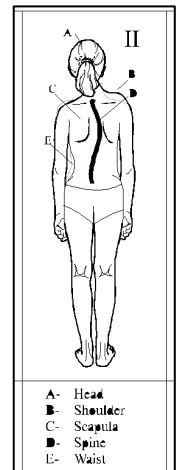
Position 1:

- Student faces screener, standing erect but relaxed with feet close together, weight evenly distributed, knees straight, arms at sides, and eyes straight ahead
- Observe:
 - Is one shoulder higher than the other?
 - Is the waistline the same on both sides, or is there a larger space between the arm and flank on one side?
 - Are hips level and symmetrical, or is one side higher or more prominent?
- Make a referral if any 2 of the 3 listed above are present



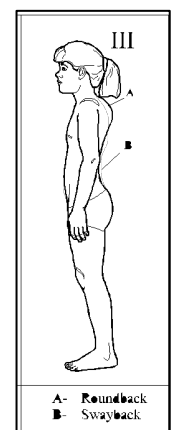
Position 2:

- Student faces away from screener, with long hair either pinned up or brought in front of shoulders so screener can observe the student's entire back
- Observe:
 - Does the student's head lean to one side?
 - Is one shoulder higher than the other?
 - Is one shoulder blade more prominent than the other?
 - Is there a spinal curvature?
 - Is the waistline the same on both sides, or is the arm-to-body space uneven?
- Make a referral if any 3 of the 5 listed above are present



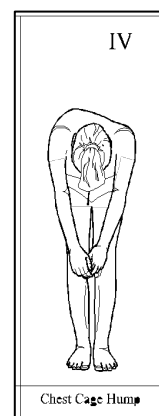
Position 3:

- Student stands erect with his/her side facing screener
- Observe:
 - Is there an accentuated roundness in the upper back?
 - Is there an accentuated arching in the lower back?
- Make a referral if either of the 2 listed above is present



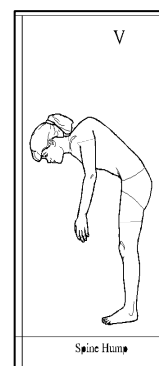
Position 4:

- Student bends forward until back is parallel to the floor
- Student should have feet together, knees straight, palms of hands together, and head down
- Examine from the front and back view
- Observe:
 - Is there a rib hump on one side?
- Make a referral if rib hump on one side is present



Position 5:

- Student bends forward from Position 4 and stops just before back is parallel to the floor
- Examine from the side
- Observe:
 - Is there an exaggerated midline hump?
- Make a referral if exaggerated midline hump is present



Protocols for Filling Out the Postural Screening Worksheet

It is important that the screener include as much information as possible about his/her findings for easy reference in the rescreening.

Using MDPH's postural screening worksheet can assist you in the screening process. The pictures on the worksheet represent the positions in which the student is viewed by the screener. The front, back, and side views each have several areas of focus. Each area has a letter designation. Use these letters to represent positive findings. Indicate whether positive findings are on the student's left or right side (not the screener's left/right). Positive findings in Position 4 and 5 can be indicated by a checkmark. A link to this worksheet is available in the [SHIELD Health Screenings webpage](#)

Postural Screening Referral and Follow-Up

Students who were absent on screening day should be screened at another time. Any student who was excluded from screening for any other reason should have that reason documented.

If there was no positive finding in a student's initial screening, his/her parents/guardians do not need to be contacted.

Children with positive findings should be scheduled for a rescreening by the school nurse. Typically, 1 in 10 students is targeted for referral after rescreening. A separate session should be scheduled to rescreen all students who had a positive finding. It is recommended that the student's original worksheet be used during their rescreening.

- If positive findings are not confirmed, parents/guardians do not need to be contacted
- If a positive finding is confirmed, the following steps for a referral should be taken:
 - Contact family via phone (if unavailable by phone, send letter) to explain that a medical follow up is being recommended as a precaution.
 - Send follow up letter to parents
 - Get student's physician's info from the family and send letter to physician

Primary care providers in the community should be informed about the school's postural screening program. Developing collaborative relationships with these providers will facilitate the referral and follow-up process.

The school nurse should maintain a record of referred students whose physicians reported nothing wrong, but about whom there is a continued concern on the part of the screener. These students ought to be rescreened in 3 to 6 months. If the screener's concerns persist, the family should be contacted and encouraged to get a second physician's opinion.

The school nurse and physical education teacher should both be informed about students whose physicians have prescribed a brace. The school nurse may need to supervise skin care. In most cases, students who wear braces will still be encouraged to participate in a wide range of physical education activities.

Postural Documentation and Reporting

MDPH's postural screening worksheet should be used to document positions in which the student is viewed by the screener, any positive findings, and follow-up activities.

Note that in the MDPH Postural Screening Program Training Material (Revised 1996), Section 4.5: Record Keeping and Final Report states that districts must submit a summary statistical postural screening report form annually by July 15. **These reports are no longer required.**

Report aggregate data to MDPH for CSHS grant recipients.

Vision Screening

Vision Screening Equipment and Tools

Vision screening protocols were revised on August 23, 2021.

Effective September 1, 2022, the following vision screening tools may no longer be used:

- Random Dot E
- Vision testing machines (e.g., Optec, Titmus, Keystone View)
- All visual acuity charts that do not use logMAR notation and scoring (vision acuity charts must now use LEA SYMBOLS® or Sloan Letters; discontinue use of all other charts)

The following is a listing of approved tools as of September 1, 2022:

Distance Visual Acuity

Pre-K and Kindergarten (ages 3, 4, 5):

- "EyE Check" Flipbook with LEA SYMBOLS® at 5 ft; **OR**
- Massachusetts Sight Line" Flipbook with LEA SYMBOLS® at 10 ft; **OR**
- Instrument-based screening (when instrument-based screeners are used, near visual acuity assessments must still be performed)

Grades 1-3:

- "Massachusetts Sight Line" Flipbook w/ LEA SYMBOLS® *or* Sloan Letters; **OR**
- Sloan Letters wall chart at 10 ft. distance

Grades 4-12:

- Sloan Letters wall chart at 10 ft. distance

Near Visual Acuity

Pre-K and Kindergarten (ages 3, 4, 5):

- LEA SYMBOLS® near card with 16-inch cord attached (when instrument-based screeners are used for distance visual acuity, near visual acuity using this tool must still be performed)

Grades 1-3:

- LEA SYMBOLS® *or* Sloan Letters near card with 16-inch cord attached

Stereoacuity

Kindergarten and Grades 1-3:

- "PASS 1 Smile Test" at 16-inch distance

Equipment is available to purchase from a variety of vendors, however, it can be difficult to determine which tools to order. A detailed list of equipment, including model numbers, is available on [SHIELD's Health Screenings webpage](#).

Take note that instrument-based vision screening is approved *only* for children aged 3, 4, and 5 years old, AND, when instrument-based screeners are used, near visual acuity assessments must still be performed. According to the American Academy of Pediatrics (AAP)'s Instrument-Based Pediatric Vision Screening Policy Statement (2012), instrument-based screening devices are recommended as an alternative to visual acuity screening with vision charts for the 3-5 year old age group. Regardless of the type of photoscreening or autorefraction system used (e.g., Spot™, Pluoptix, Retinomax), screeners should know how to use and apply the technology properly and understand the limitations of the instrument and test in relation to the children's age. If your school acquires one of these devices, staff should be knowledgeable and trained in the use of the technology and ensure privacy with any transfer of electronic data into a student health record. School nurses interested in this technology should contact their Regional School Nurse Consultant for guidance.

English language learners: Instrument-based screening for children ages 3, 4, and 5-years, and/or matching lap cards with visual acuity charts can be used when testing the vision of children who are non-English proficient.

Vision Screening Protocols

Screening Tips

- Ensure good lighting for accurate screening results.
- Be sure to measure distances accurately. If a screening location cannot accommodate the required distances, find a different area to conduct screenings.
- Know the *Signs of Possible Vision Problems in Children*, published by Prevent Blindness, and refer if your nursing assessment suggests a potential vision problem even if the child passes the vision screening.
- Pointing to letters or symbols is recommended only if a child loses their place, and should be a point and remove method (not continuing to point to the letter to be read).
- Do a skills assessment with your screening team to ensure accurate application of screening procedures. Check early and regularly with screening team to be sure no issues arise.
- Create a quality screening program by applying a systematic approach as listed in the *12 Components of a Strong Vision Health System of Care* designed by the National Center for Children's Vision and Eye Health.

Revised Vision Screening Protocols

Vision screening protocols were revised August 23, 2021 (effective 9/1/22). The new guidance document, *Updated Massachusetts Vision Screening Protocols*, can be found on [SHIELD's Health Screenings webpage](#). The chart below summarizes the changes to vision screening protocols. Details on the required screening tests for each grade are provided in the table at the end of this vision screening section.

Changed item	Prior to 9/1/22	Additions/Changes (effective 9/1/22)
Critical passing line	36-47 months: 20/40 48 months & up: 20/30	Preschool (3 years): 20/50 Preschool (4+ years): 20/40 Kindergarten (5 years) through Gr. 12: 20/32
Annual screening of public preschoolers	Optional	Mandatory
All visual acuity charts to use logMAR notation	Varied options	Discontinuation of all charts not in logMAR notation
Near visual acuity screening	Annually Gr. 1-12	Upon school entry, or ages 3 yrs (Pre-K0) through Gr. 3
Distance visual acuity screening (ages 3, 4, & 5 yrs)	Mass VAT: LEA SYMBOLS® HOTV	"Sight Line" at 10 ft or EyECheck at 5ft LEA SYMBOLS® (w/ optional matching lap card if child is unsure of letters or is an ELL)
Distance visual acuity screening (ages 6 yrs+)	Any line letters, LEA NUMBERS®, Tumbling Es, HOTV VAT testing machines	Kindergarten see above. Gr. 1 and up: Sloan Letters (w/ optional lap card) LEA SYMBOLS® (w/ optional matching lap card if child is unsure of letters or is an ELL)
Stereoacuity screening	Random Dot E (Pre-K through Gr. 3)	Pass 1 Smile Test (Kindergarten through Gr. 3)
Visual acuity testing machines	Optec, Titmus, Keystone View	Discontinued
Instrument-based screening (ages 3, 4, & 5 yrs)	Approved for use	Near visual acuity must be conducted <i>in addition</i> . Instrument-based screening alone can replace distance visual acuity screening and stereoacuity screening. Use in Kindergarten only for children age 5 years.
Instrument-based screening (ages 6 years+)	Not approved for use	Children ages 6 yrs+ who cannot participate in approved letter or symbol visual acuity screenings are to be referred for a comprehensive eye exam by an eye doctor who is experienced in treating children.

Vision Screening Referral and Follow-Up

Any child who does not meet the passing criteria shown in the charts above must be referred.

Timely referral and follow-up of children who have failed their vision screening is of utmost importance. Permanent vision loss can occur if a referral is not completely quickly.

Additionally, the school nurse must ensure that any student diagnosed with neurodevelopmental delay has documentation of an annual eye examination in their school health record. If this documentation is not available, or the child has not been seen by a provider, the student should be referred for evaluation.

MGL Ch71, s57 requires any person who conducts an eye exam of a student referred through a school screening program to report the results to school health personnel. A copy of the report must go to the student's parents/guardians, and they should be encouraged to share a copy of the eye specialist's report with their child's primary care provider. School nurses may need to pursue obtaining these important documents.

Finally, note that some students may pass their vision screening, but the school nurse, teachers, and/or support staff (e.g., special education teacher, reading specialist) may notice symptoms that suggest a potential vision disorder. For example, a child may have regular headaches, squint in class, or have difficulty with reading. These children should also be referred for evaluation regardless of their vision screening results.

Vision screening is the first step in identifying children who may have an undetected vision problem that requires evaluation by an eye doctor experienced in diagnosing and treating children. The referral process begins with notifying parents and caregivers of the need for an examination by an eye doctor, with a systematic process in place for periodic parental reminders, notation of eye exam results, and sharing of results with the child's teachers where appropriate.

There are many reasons why a child may not receive timely vision care. School Nurses along with other educational and health personnel must consider the unique barriers to care when developing referral and follow up systems that are individualized to families and communities. Some of these considerations include factors related to the social determinants of health, such as socio-economic status, homeless status, insurance status, access to eye care services, cultural, racial, and other areas of discrimination. All personnel must work towards engaging families and providers to mitigate these barriers to vision follow up and care. MDPH strongly advises co-creating solutions with the parent or caregiver to enable the child to receive the necessary vision care treatment, including providing linguistically and culturally-appropriate informational materials about childhood vision and the importance of follow-up eye exams, so the child will receive, and remain in, eye care.

MDPH recommends that a comprehensive eye exam by an eye doctor experienced in treating children be sought in the following cases:

- Children unable to complete, or who refuse to complete, a vision screening, if unable to be re-screened in a timely manner
- Children with complex or multiple disabilities (special health care needs) whose disability or behavior prevents them from performing a standard screening
- Children not reaching educational milestones, or who are being considered for, or receive, additional educational support (i.e., Individualized Education Plans), even if the child has passed a recent vision screening
- Parent, teacher, nurse, or screener concerns about a potential vision problem (i.e., signs or complaints from child), even if child has passed a recent vision screening
- Frequently observed classroom behaviors that may indicate a vision problem (screeners, school nurses, teachers, and other staff interacting with children are advised to understand factors which can influence the likelihood of a child having/developing a vision disorder; and be especially aware of frequently exhibited behaviors that may indicate a possible vision problem, even if the child has passed a recent vision screening)

In each case, parents should fully understand the necessity for the referral.

Sharing of Vision Screening and Plan of Care with Teachers

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a federal law that protects the privacy of student education records. FERPA privacy rules allow sharing of information without parent authorization amongst school personnel who have a legitimate educational interest in that child. Records maintained by a school nurse and any health screening conducted by the school or by an agency contracted by the school, is an education record regulated by FERPA privacy laws, not a health record regulated by HIPAA privacy laws. School-based clinic provider medical records can be regulated by HIPAA. Sharing a student's vision screening result and treatment plan with their teacher, reading specialist, IEP provider, or school personnel with legitimate educational interest is encouraged in situations where compliance with referral or treatment is not being followed.

Assistance with Glasses

For families with economic challenges, glasses and eye exams may be available from resources such as the Lions Club, the National Association of School Nurses, MassHealth, and others. [The National Center for Children's Vision and Eye Health](#) and [Children's Vision Massachusetts](#) have tremendous collections of resources for nurses, educators, and families. These resources can be accessed through [SHIELD's Health Screenings webpage](#).

Vision Documentation and Reporting

All vision screening results (passes, referrals, and referral results) should be recorded on the student's school health record. A link to the Massachusetts School Health Record Form is provided in [SHIELD's Health Screenings webpage](#).

If the referral confirms a vision problem, the school health record card should also indicate the nature of the abnormality as determined by the specialist, and a complete record of any treatment prescribed. MGL Ch71, s57 was amended in 1987 and now requires any person who conducts an eye exam of a student referred through a school screening program to report the results to school health personnel. A copy of the report must go to the student's parents/guardians, and they should be encouraged to share a copy of the eye specialist's report with their child's primary care provider.

The report must, at a minimum, include the following:

- date of report
- student's name and address
- name of student's school
- type of examination
- summary of significant findings, including diagnoses, medication, duration of medication's action, prognosis, whether a return visit is recommended (and if so, when)
- any recommended educational adjustments (i.e., preferential seating in the classroom, eyeglasses for full- or part-time use in school and/or home, use of low-vision aids)
- name, address, and signature of the examiner

Report aggregate data to MDPH for CSHS grant recipients.

Massachusetts Vision Screening Guidelines for Pre-K – Gr. 12

Pre-K	Frequency of Screening	Elements of Assessment	Critical Passing Line or Performance Criteria	Approved Screening Methods/Recommended Tools			Recommended Follow Up
	Annually	Distance Visual Acuity (Monocular)	Age 3 yrs: 20/50	"Eye Check" Flipbook with LEA SYMBOLS® at 5 ft.* OR "Massachusetts Sight Line" Flipbook with LEA SYMBOLS® at 10 ft.* ALL ages must identify 4 out of 5 symbols presented.*	OR**	Instrument-Based Screening (Spot™, Plusoptix [without the visual acuity add-on component], Retinomax) for children ages 3, 4, and 5 years. When instrument-based screeners are used, near visual acuity assessments must still be performed.	• Document screening results in student health record. • Notify teachers or staff per FERPA guidelines. • Refer students who do not pass screening for a Comprehensive Eye Examination from a licensed Ophthalmologist or Optometrist trained and experienced in treating young children and provide follow up when needed. • Assist families with identification and mitigation of any barriers to care (e.g., lack of insurance, access to care, language barriers, etc.). Ensuring timely access to vision care is critical to avoiding delays in treatment that may lead to permanent vision loss or a decrease in visual ability. • Develop plans of care & follow up when needed.
			Ages 4+ yrs: 20/40				
		Near Visual Acuity (Binocular)	Age 3 yrs: 20/50	LEA SYMBOLS® near card with 16-inch cord attached. Must Identify 4 out of 5 symbols presented at 16-inch distance.			
			Ages 4+ yrs: 20/40				
Kindergarten	Frequency of Screening	Elements of Assessment	Critical Passing Line or Performance Criteria	Approved Screening Methods/Recommended Tools			Recommended Follow Up
	Annually	Distance Visual Acuity (Monocular)	20/32	"Eye Check" Flipbook with LEA SYMBOLS® at 5 ft. * OR Massachusetts Sight Line" Flipbook with LEA SYMBOLS® at 10 ft. * ALL ages must identify 4 out of 5 symbols presented.*	OR**	Instrument-based Screening (Spot™, Plusoptix [without the visual acuity add-on component], Retinomax) for children ages 3, 4, and 5 years. When instrument-based screeners are used, near visual acuity assessments must still be performed.	• Document screening results in student health record. • Notify teachers or staff per FERPA guidelines. • Refer students who do not pass screening for a Comprehensive Eye Examination from a licensed Ophthalmologist or Optometrist trained and experienced in treating young children and provide follow up when needed. • Assist families with identification and mitigation of any barriers to care (e.g., lack of insurance, access to care, language barriers, etc.). Ensuring timely access to vision care is critical to avoiding delays in treatment that may lead to permanent vision loss or a decrease in visual ability. • Develop plans of care & follow up when needed.
		Near Visual Acuity (Binocular)	20/32	LEA SYMBOLS® near card with 16-inch cord attached. Must identify 4 out of 5 symbols presented at 16-inch distance.			
		Stereopsis (Binocular)	Identify smiley face	"PASS 1 Smile Test" at 16-inch distance. Must identify "smiley face" 4 out of 5 times randomly presented at 16-inch distance.			
PLEASE NOTE: Per MGL Ch 71, s57, students diagnosed with neurodevelopmental delay should be referred for a comprehensive eye exam from an eye doctor, if they have not presented the school with proof of such upon school entry.							
* Verbal naming or matching lap card options are acceptable and may be useful for some students who do not verbalize a response or for those with limited English proficiency.							
** Instrument-based screening can be done in place of distance visual acuity and stereopsis for children up to age 6 years ONLY. Near visual acuity also must be assessed.							

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Massachusetts Vision Screening Guidelines for Pre-K – Gr. 12

Gr. 1-3	Frequency of Screening	Elements of Assessment	Critical Passing Line or Performance Criteria	Approved Screening Methods/Recommended Tools	Recommended Follow Up
	Annually	Distance Visual Acuity (Monocular)	20/32	"Massachusetts Sight Line" Flipbook w/ LEA SYMBOLS® or Sloan Letters *; OR Sloan Letters wall chart at 10 ft. distance.* Must identify 4 out of 5 symbols or letters. *	• Document screening results in student health record. • Notify teachers or staff per FERPA guidelines. • Refer students who do not pass screening for a Comprehensive Eye Examination from a licensed Ophthalmologist or Optometrist trained and experienced in treating young children and provide follow up when needed. • Assist families with identification and mitigation of any barriers to care (e.g., lack of insurance, access to care, language barriers, etc.). Ensuring timely access to vision care is critical to avoiding delays in treatment that may lead to permanent vision loss or a decrease in visual ability. Develop plans of care and follow up when needed.
		Near Visual Acuity (Binocular)	20/32	LEA SYMBOLS® or Sloan Letters near card with 16-inch cord attached. Must identify 4 out of 5 symbols presented at 16-inch distance.	
		Stereopsis (Binocular)	Identify smiley face	"PASS 1 Smile Test" at 16-inch distance. Must identify "smiley face" 4 out of 5 times randomly presented at 16-inch distance.	
Gr. 4-5	Frequency of Screening	Elements of Assessment	Critical Passing Line or Performance Criteria	Approved Screening Methods/Recommended Tools	Recommended Follow Up
	Annually	Distance Visual Acuity (Monocular)	20/32	Sloan Letters wall chart at 10 ft. distance.* Must identify 4 out of 5 letters.*	• Document screening results in student health record. • Notify teachers or staff per FERPA guidelines. • Refer students who do not pass screening for a Comprehensive Eye Examination from a licensed Ophthalmologist or Optometrist trained and experienced in treating young children and provide follow up when needed. • Assist families with identification and mitigation of any barriers to care (e.g., lack of insurance, access to care, language barriers, etc.). Ensuring timely access to vision care is critical to avoiding delays in treatment that may lead to permanent vision loss or a decrease in visual ability. • Develop plans of care and follow up when needed.
		Near Visual Acuity (Binocular)	N/A	N/A	
		Stereopsis (Binocular)	N/A	N/A	
PLEASE NOTE: Per MGL Ch. 71, s57, students diagnosed with neurodevelopmental delay should be referred for a comprehensive eye exam from an eye doctor, if they have not presented the school with proof of such upon school entry.					
* Verbal naming or matching lap card options are acceptable and may be useful for some students who do not verbalize a response or for those with limited English proficiency.					
** Instrument-based screening can be done in place of distance visual acuity and stereopsis for children up to age 6 years ONLY. Near visual acuity also must be assessed.					

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Massachusetts Vision Screening Guidelines for Pre-K – Gr. 12

Gr. 6-8	Frequency of Screening	Elements of Assessment	Critical Passing Line or Performance Criteria	Approved Screening Methods/Recommended Tools	Recommended Follow Up
	Once ONLY in Grades 6-8	Distance Visual Acuity (Monocular)	20/32	Sloan Letters wall chart at 10 ft. distance.* Must identify 4 out of 5 letters.*	• Document screening results in student health record. • Notify teachers or staff per FERPA guidelines. • Refer students who do not pass screening for a Comprehensive Eye Examination from a licensed Ophthalmologist or Optometrist trained and experienced in treating young children and provide follow up when needed. • Assist families with identification and mitigation of any barriers to care (e.g., lack of insurance, access to care, language barriers, etc.) Ensuring timely access to vision care is critical to avoiding delays in treatment that may lead to permanent vision loss or a decrease in visual ability. • Develop plans of care and follow up when needed.
		Near Visual Acuity (Binocular)	N/A	N/A	
		Stereopsis (Binocular)	N/A	N/A	
Gr. 9-12	Frequency of Screening	Elements of Assessment	Critical Passing Line or Performance Criteria	Approved Screening Methods/Recommended Tools	Recommended Follow Up
	Once ONLY in Grades 9-12	Distance Visual Acuity (Monocular)	20/32	Sloan Letters wall chart at 10 ft. distance.* Must identify 4 out of 5 letters.*	• Document screening results in student health record. • Notify teachers or staff per FERPA guidelines. • Refer students who do not pass screening for a Comprehensive Eye Examination from a licensed Ophthalmologist or Optometrist trained and experienced in treating young children and provide follow up when needed. • Assist families with identification and mitigation of any barriers to care (e.g., lack of insurance, access to care, language barriers, etc.) Ensuring timely access to vision care is critical to avoiding delays in treatment that may lead to permanent vision loss or a decrease in visual ability. • Develop plans of care and follow up when needed.
		Near Visual Acuity (Binocular)	N/A	N/A	
		Stereopsis (Binocular)	N/A	N/A	
PLEASE NOTE: Per MGL Ch. 71, s57, students diagnosed with neurodevelopmental delay should be referred for a comprehensive eye exam from an eye doctor, if they have not presented the school with proof of such upon school entry.					
* Verbal naming or matching lap card options are acceptable and may be useful for some students who do not verbalize a response or for those with limited English proficiency.					
** Instrument-based screening can be done in place of distance visual acuity and stereopsis for children up to age 6 years ONLY. Near visual acuity also must be assessed.					

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