

**Your child's pediatrician will have this form.**

Georgia Department of Human Resources

**CERTIFICATE OF EAR, EYE AND DENTAL EXAMINATIONS  
TO BE FILED WITH SCHOOL AT TIME OF CHILD'S ENROLLMENT**

*This is to verify that the child identified here has received or been excused  
for special or provisional reasons from receiving EXAMINATIONS, TESTS or INSPECTIONS.*

**IDENTIFYING INFORMATION**

CHILD'S NAME First _____ Middle _____ Last _____			DATE OF BIRTH Mo. _____ Day. _____ Yr. _____		
LOCAL RESIDENCE (Street & Number, P.O. Box, Route, Etc.) _____			SCHOOL _____		
CITY _____		STATE & ZIP CODE _____		COUNTY _____	
PARENT'S NAME _____			ADDRESS (Street or R.F.D. No., City or Town, State) _____		
			SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		
			RACE <input checked="" type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other		

**EYE-VISION**

<input checked="" type="checkbox"/> Screening Test	<input checked="" type="checkbox"/> Passed
<input type="checkbox"/> Needs Further Professional Examination	
<input type="checkbox"/> Special Certificate	
<input type="checkbox"/> Provisional Certificate	
<b>EXAMINATION DONE BY</b>	<b>DATE</b>
<input type="checkbox"/> County Health	
<input type="checkbox"/> Volunteer Organization	
<input checked="" type="checkbox"/> Private Practitioner	
<b>EXAMINER'S SIGNATURE</b>	<b>TITLE</b>

**EAR-HEARING**

<input checked="" type="checkbox"/> Screening Test	<input checked="" type="checkbox"/> Passed
<input type="checkbox"/> Needs Further Professional Examination	
<input type="checkbox"/> Special Certificate	
<input type="checkbox"/> Provisional Certificate	
<b>EXAMINATION DONE BY</b>	<b>DATE</b>
<input type="checkbox"/> County Health	
<input type="checkbox"/> Volunteer Organization	
<input checked="" type="checkbox"/> Private Practitioner	
<b>EXAMINER'S SIGNATURE</b>	<b>TITLE</b>

**DENTAL**

<input type="checkbox"/> Normal Appearance (Green)	
<input type="checkbox"/> Needs Further Professional Examination (Yellow)	
<input type="checkbox"/> Emergency Observed Problem (Red)	
<input type="checkbox"/> Special Certificate	
<input type="checkbox"/> Provisional Certificate	
<b>EXAMINATION DONE BY</b>	<b>DATE</b>
<input type="checkbox"/> Public Health: Dentist, Hygienist, PH/School R.N.	
<input type="checkbox"/> Private Practitioner: Dentist, Physician	
<b>EXAMINER'S SIGNATURE</b>	<b>TITLE</b>

**FOR INFORMATION:** Contact your COUNTY HEALTH DEPARTMENT or your PRIVATE Practitioner

**CHILDREN'S MEDICAL GROUP, P.C.**

1875 CENTURY BLVD., N.E.  
SUITE 150  
ATLANTA, GA 30345  
(404) 633-4595

**FOR INSTRUCTIONS:** See reverse side of page

**FRONT**