Daim Ntawv Xa Tawm Mus Kuaj Qhov Muag

Tus Menyuam Lub Npe: _____ Hnub Yug: _____

Nyob Zoo Txog cov Niam thiab Txiv/Cov Neeg Saib Xyuas:

Peb lub tsev kawm ntawv muab kev kuaj qhov muag es yog siv daim qauv cob qhia tsim tawm los ntawm lub tuam tsev Minnesota Department of Health. Koj tus menyuam raug kuaj qhov muag rau hnub_____.

Thov coj koj tus menyuam mus ntsib tus kws kuaj qhov muag mus kuaj qhov nws pom kev. Thov muab daim ntawv no nrog cov ntaub ntawv es kuaj tag pom dabtsi rau koj tus kws kuaj qhov muag.

- ☐ Qhov muag sab xis 10/_____ (20/_____) Qhov muag sab laug 10/_____ (20/_____) / rau qhov pom deb.
- ☐ Koj tus menyuam tsis muaj peev xwm nyeem cov kab ntawv nyob rau daim ntawv chart ntawm lawv lub hnub nyoog LOS YOG qhov sib txawv ntawm qhov pom kev rau lub qhov sab laug thiab sab xis sib txawv deb tshaj li ib kab (nrog) (tsis nrog) daim iav sim es haum nws.
- ☐ Koj tus menyuam muaj teeb meeb pom cov khoom es nyob ze ze (Kuaj qhov pom kev ze (Plus lens screening))
- ☐ Koj tus menyuam yws tias nyuaj heev rau nws pom kev kom zoo zoo.
- ☐ Qhov es saib pom ntawm koj tus menyuam lub qhov muag mas tsis zoo tib yam li feem ntau ntawm cov menyuam lub qhov muag. Piav ntxiv:
  _____
- ☐ Tej zaum kuj yog tias muaj teeb meem rau cov leeg ntawm lub qhov muag es rub los tsis haum (lub noob muag saib mus rau tib seem) yeej tau pom thaum lub sij hawm kuaj.
- ☐ Ob lub ntsiab muag saib tsis mus tib seem (Abnormal Retinal (Red Light) Reflex)
- ☐ Tus menyuam/Tsev neeg qhov keeb kwm muaj teeb meem txog qhov muag.

Yog tias koj muaj lus nug los yog xav tau kev pab kom muaj qhov kev kuaj qhov muag los ntawm tus kws kuaj qhov muag, thov tiv tauj peb.

_____

Thov hais kom koj tus kws kuaj qhov muag ua kom tiav daim ntawv thiab xa daim ntawv es ua tiav lug rov qab mus rau koj lub tsev kawm ntawv.

Health Care Provider, please complete this form.

Child's Name: _____ Date of Birth: _____

School Name: _____

Provider comments:

I have examined this child on_____/_____/_____

My findings are:

Right: 10/_____ (20/_____) Left: 10/_____ (20/_____) without corrective lenses

- ☐ Insufficient to require treatment
- ☐ Corrective lenses prescribed or there is change in the current prescription.
- ☐ Best Correction: R_____/_____ L_____/_____
- ☐ Muscular Condition was not found or insufficient to require treatment
- ☐ Muscular Condition is being treated by corrective lenses or other method
- ☐ There is no significant visual condition that will impact the child's learning
- ☐ This child has a visual condition that may impact learning. Recommendations include:
- ☐ _____
- ☐ Other _____

Child should return for follow up examination on _____

Provider Name/Title: _____

Contact Information: _____

Schools nurse or health staff fill out this section below before sending home

Please have the parent return this form to the school or you can return this to

School Nurse Name: _____

Phone: _____

Address: _____

_____

Email: _____

Daim qauv ntawm daim ntawv no yog tsim tawm los ntawm MDH es siv rau hauv cov tsev kawm ntawv.

Minnesota Department of Health
Child and Teen Checkups
651-201-3650
health.childteencheckups@state.mn.us
www.health.state.mn.us

12/2023

Kom tau daim qauv no es yog lwm hom format, hua rau: 651-201-3650.