DEPARTMENT OF HEALTH

Ge-dibaabamind Awiya Oshkiinzhigong

Ezhi-wiinind a'aw Abinoojiinh: _____

Apii gaa-ondaadizid: _____

Aaniin Weniijaanisiyeg/Genawenimegig abinoojiinyag:

Odaa-dibaamaawag ingiw abinoojiinyag epiichi-nitaa-inaabiwaad. Mii iw Minnesota Department of Health gaa-onzikaamagak ge-gikenjigaadenig ezhi-nitaa-inaabiwaad ingiw abinoojiinyag. Ishkwaaj gii-tibaabamaa giniijaanis o'owapii_____.

Indaga naa izhiwizh gidaabanoojiinyim iwidi da-waabamaad oshkiinzhigoo-mashkikiiwininiwan ge-dibaabamigod epiichi-nitaa-inaabid. Indaga naa miizh a'aw oshkiinzhigoo-mashkikiiwinini o'ow mazina'igan da-gikenjigaadenig ezhi-apiichi-nitaa-inaabinid gidaabinoojiinyiman gaa-izhi-dibaabamimind omaa gikinoo'amaadiiwigamigong.

- Gwayako-shkiinzhig 10/_____ (20/_____) Namanji-shkiinzhig 10/_____ (20/_____) waasaa epiichi-inaabid.
- Gaawiin ogii-gashkitoosiin da-agindang i'iw gaa-ozhibii'igaadenig agwaakwa'iganing eni-apiitizid GEMAA mii go gii-izhi-bakaanak epiichi-inaabid imaa onamanjishkiinzhigong miinawaa dash iwidi bezhig imaa gwayako-shkiinzhigong, naa gaye gaa-apiichi-inaabid nawaj dash bangii i'iw agaasaabii'igaadenig. (biizikang) (biizikanzig) oshkiinzhigookaanan.
- Gaawiin gii-nitaa-inaabisiin beshwaabandang gegoo. (Oshkiinzhigookaajigaansan dagosijigaadenig weweni da-beshwaabandang gegoo).
- Bi-dibaajimo gidaabinoojiinyim ezhi-nitaa-inaabisig.
- Gaawiin-igo de-izhinaagozisiin gidabinoojiinyim oshkiinzhigoon dibishkoo aanind aya'aan abinoojiinyan. Dibaajim:_____
- Ganabaj zanagadini eni-inaabid a'aw gidaabinoojiinyim naasaab apii oshkiinzhigoon mamaajiisenig. (Mii go nayenzh gidooshkiinzhigoon weweni mamaajiiseg naasab apii.) gii-waabanjigaadenig megwaa gii-dibaabimigod gidabinoojiinyim
- Mamaanaabi-inaapinewin(Miskwaakoseg)
- Mii ko gaa-izhi-ayaad gidaabinoojiinyim gemaa awiya enawemad oshkiinzhigong.

Giishpin wii-kagwedweyan gegoo gemaa misawendaman awiya wiidookook nandawaabamad aya'aan oshkiinzhigoo-mashkikiiwininiwan da-dibaabamigooyan epiichi-nitaa-inaabiyan, daga bi-ganoozhishinaang.

Odaa-mooshkinebii'aan o'ow mazina'igan a'aw gidooshkiinzhigoo-mashkikiiwinini, mii dash ge-izhi-bi-azhe-giiwewidooyan imaa gigikinoo'amaadiiwigamigong.

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: _____

This templated form was developed by MDH for use in schools.

Minnesota Department of Health
Abinoojiinyag miinawaa Weshki-aya'awijig Debaabiminjig
651-201-3650
health.childteencheckups@state.mn.us
www.health.state.mn.us

01/2025

To obtain this templated in a different format, call: 651-201-3650.