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Child's Name: _____ Screening Location: _____
Birthday: _____ Age: _____
Parent/Guardian Name: _____ City: _____
Address: _____ Zip: _____
Phone: _____
Does child have Medicaid? ☐ Yes ☐ No (Medicaid will be billed for screening)

Please sign: _____

Please share these results with your child's primary care provider

BRIEF HEARING HISTORY *To be filled out by parents*

1. Has the child been seen by a doctor for any ear problem? _____
   Reason: _____
   Doctor: _____ When? _____
2. Is the child on medication for cold/allergies? _____
3. As a parent, do you have any concerns regarding your child's hearing? _____

HEARING SCREENING *STAFF USE ONLY*

Technician: _____ RESULTS: ☐ Passed ☐ Referred
Date of screening: _____ ☐ Under Care ☐ Unable to screen

BRIEF EYE HISTORY *To be filled out by parents*

1. Has your child ever been examined by an eye doctor? ☐ Yes ☐ No
   When? _____ Reason? _____
2. Name of eye doctor? _____
3. When child is ill/tired, do the eyes appear crossed or does one eye wander when looking at an object? ☐ Yes ☐ No

VISION SCREENING *STAFF USE ONLY*

I. **Visual Acuity**

	20/40		**20/25**	
Both eyes	0 1 2 3	4 5 6	0 1 2 3	4 5 6
Right eye	0 1 2 3	4 5 6	0 1 2 3	4 5 6
Left eye	0 1 2 3	4 5 6	0 1 2 3	4 5 6

	Passed	Failed	**RESULTS**
Stereo Butterfly Test			☐ Passed ☐ Referred
			☐ 2-Line Difference
			☐ Failed not referred
			☐ Under Care

III. Eye History

IV. Symptom Referral

Technician:

Date of Screening: