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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			Technician:
IV. Symptom Referral			Date of Screening: