BERRIEN COUNTY HEALTH DEPARTMENT
PRESCHOOL HEARING AND VISION FORM

SCREENING LOCATION: ____________________ **SCREENING DATE:** ____________________

CHILD'S NAME: ____________________ BIRTHDATE: ____________ AGE ____________

PARENT/GUARDIAN'S NAME: ____________________ STARTING KDG AT: ____________________
School

ADDRESS: ____________________ CITY: ______________ ZIP: __________ PHONE: ______________

BRIEF HEARING HISTORY

1. Has your child been to a doctor for **any** ear problems? **2.** Does your child have a shunt for hydrocephalus? YES NO

When: ______________ **Reason**: ____________________ **Dr.'s Name**: ______________

3. Is child on medication for cold/allergies? ______ Tonsils removed? ______ Adenoids Removed? ______ Tubes? ______

4. Do you have any concerns regarding your child's hearing? ____________________

BRIEF EYE HISTORY

1. Has your child ever been to an **eye** doctor? YES NO *If YES* Name? ____________________

When? ____________________ **Why?** ____________________

2. Does your child wear glasses? YES NO **3.** Has your child ever had eye surgery? YES NO

4. When your child is ill or tired, do their eyes cross or one eye wander? YES NO

DO NOT WRITE BELOW THIS LINE

I. Visual Acuity

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

	PASSED	FAILED
II. Corneal Reflection	______	______
III. Cover/Uncover Test: Near		
Right eye movement	______	______
Left eye movement	______	______
Cover/Uncover Test: Far		
Right eye movement	______	______
Left eye movement	______	______
IV. Eye History	______	______
V. Symptom Referral	______	______

VISION RESULTS

PASSED **UNDER CARE**

REFERRED ON ____________________

FAIL NOT REFER ____________________

____
Technician **Date**

HEARING RESULTS

PASSED **RESCREEN** **REFERRED** **UNDERCARE**

Right	**1000**	**2000**	**4000**
Left	**1000**	**2000**	**4000**

____
Technician **Date**