BERRIEN COUNTY HEALTH DEPARTMENT
PRESCHOOL/KINDERGARTEN HEARING AND VISION FORM

SCREENING LOCATION: _____ **SCREENING DATE:**_____

CHILD'S LEGAL NAME: _____ BIRTHDATE:_____ AGE_____ MALE OR FEMALE

MEDICAID NUMBER: _____ CHILD'S PRIMARY LANGUAGE: ENGLISH OTHER_____

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

HOME ADDRESS: _____ CITY:_____ ZIP:_____ PHONE:_____

BRIEF HEARING HISTORY

1. **Does your child have a shunt for hydrocephalus? YES NO**
2. Has your child been to a doctor for **any** ear problems? **When:**_____ **Reason**:_____
3. Is child on medication for cold/allergies?_____ Tonsils removed?_____ Adenoids Removed?_____ Tubes?_____
4. Do you have any concerns regarding your child's hearing? YES NO

If YES, please explain: _____

BRIEF EYE HISTORY

1. Has your child ever been to an **EYE** doctor? YES NO Dr.'s Name?_____

   When:_____ **Reason:**_____
2. Does your child wear glasses? YES NO
3. When your child is ill or tired, do their eyes cross or one eye wander? YES NO
4. Has your child ever had eye surgery? 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. Stereo Butterfly	_____	_____
III. Eye History	_____	_____
IV. Symptom Referral	_____	_____

VISION RESULTS

PASSED	PERM. DIFFICULTY	GLASSES

REFERRED ON _____

_____
Technician

HEARING RESULTS

PASSED	RESCREEN	REFERRED	UNDER CARE
Right	**1000**	**2000**	**4000**
Left	**1000**	**2000**	**4000**

_____
Technician