BERRIEN COUNTY HEALTH DEPARTMENT
PRESCHOOL/KINDERGARTEN HEARING AND VISION FORM

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

CHILD'S LEGAL 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 Dr.'s Name? ____________________

When: ____________ **Reason:** ____________________

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

5. Does your child have seizures? 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. Cover/Uncover Test: Near		
Right eye movement	_______	_______
Left eye movement	_______	_______
Cover/Uncover Test: Far		
Right eye movement	_______	_______
Left eye movement	_______	_______
III. Corneal Reflection	_______	_______
IV. Eye History	_______	_______
V. Symptom Referral	_______	_______

R **L**

VISION RESULTS

PASSED **UNDER CARE** **GLASSES**

REFERRED ON ____________________

FAIL NOT REFER ____________________

____
Technician

HEARING RESULTS

PASSED **RESCREEN** **REFERRED** **UNDER CARE**

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

____
Technician

BCHD-HV-22 7/2013