BERRIEN COUNTY HEALTH DEPARTMENT

PRESCHOOL/KINDERGARTEN HEARING AND VISION FORM

SCREENING LOCATION: ______________________ **DATE:** ______________

CHILD'S LEGAL NAME ______________________ BIRTHDATE ____________ AGE ________

HOME ADDRESS ______________________ CITY ____________ ZIP ________ PHONE ____________

CHILD'S PRIMARY LANGUAGE ☐ ENGLISH ☐ OTHER ______________ ☐ MALE ☐ FEMALE

ATTENDING KINDERGARTEN AT ______________________________
SCHOOL

BRIEF HEARING HISTORY

1. **Does your child have a shunt or ANY other medically implanted device?** ☐ YES ☐ NO
2. Has your child been to a doctor for **any** ear problems? ☐ YES ☐ NO
3. Is child on medication for cold/allergies? ☐ YES ☐ NO
4. Does your child have a known hearing loss? ☐ YES ☐ NO
5. If you have any concerns regarding your child's hearing, please explain: ______________________

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BRIEF EYE HISTORY

1. Has your child ever been to an **EYE** doctor? ☐ YES ☐ NO 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 ☐

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
20/50 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 **A N P S W N/A**

VISION RESULTS

PASSED **PERM. DIFFICULTY** **UNABLE TO SCREEN**

GLASSES

REFERRED ON ______________________

TECHNICIAN ______________________

HEARING RESULTS

PASSED **REFERRED** **UNABLE TO SCREEN**

UNDER CARE **RESCREEN**

RIGHT	**1000**	**2000**	**4000**
LEFT	**1000**	**2000**	**4000**

TECHNICIAN ______________________