

Vision & Hearing Screener Report

Child's Name:	Birthday:	Age:
Center Name:	Classroom:	

Distance Acuity Screen:

1st Screen Date: With Corrections: <input type="checkbox"/> Yes <input type="checkbox"/> No Chart Used: <input type="checkbox"/> "E" <input type="checkbox"/> H:O:T:V: Result: Right Eye 20/_____ Left Eye 20/_____ <input type="checkbox"/> Pass <input type="checkbox"/> Re-screen Screener Initial:	Re-screen Date (Re-screen within 2 to 3 weeks): With Corrections: <input type="checkbox"/> Yes <input type="checkbox"/> No Chart Used: <input type="checkbox"/> "E" <input type="checkbox"/> H:O:T:V: Result: Right Eye 20/_____ Left Eye 20/_____ <input type="checkbox"/> Pass <input type="checkbox"/> Refer (4yr & 5yr) <input type="checkbox"/> 3yr Vision & Hearing Screener Report (3yrs only) Screener Initial:
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Sweep-Check Screening: (Identify responses with a "+"; no response with a "-")

	Ear	1 1000 Hz	2 2000 Hz	3 4000 Hz	Results
1 st Screen	R				<input type="checkbox"/> Pass <input type="checkbox"/> Re-screen
Date:	L				Screener Initial:

(Failure to respond to **ONE** (of the three) frequencies in either ear must be re-screened)

Re-screen within 3 to 4 weeks	Ear	1 1000 Hz	2 2000 Hz	3 4000 Hz	Results
Re-screen	R				<input type="checkbox"/> Pass <input type="checkbox"/> Refer (4 & 5 yr) <input type="checkbox"/> 3yr V&H Report (3yrs only)/ OAE
Date:	L				Screener Initial:

Referral to a specialist due to:

- Failed Distance Acuity Test Failed Sweep-Check Screening
 Parent / Doctor Request
 Observable Signs or Symptoms (Describe): _____
 Other: _____

Waiver of Referral

Child is being seen by a specialist, _____ (doctor's name), for the problem(s) indicated.

The tests conducted to evaluate your child's hearing and vision is a screening; it is not a diagnostic test. This means that if the child fails the screening, it is necessary for your child to be evaluated by a specialist to determine whether there is a problem. It also means that on some occasions a problem may exist that the screening will not identify.