Health Department

Hearing and Vision Program

FOR TECHNICIAN ONLY
Date: _____ / _____ / _____
Location: ____________________
Hearing: P F O NS
Vision: P F O NS
MB: ________ EMP: _______
PCP: _______ EMP: _______

Child's Legal Name: ____

Male ☐ Female ☐ Birthdate: ______ / ______ / ______ Age: __________

Year Your Child Will Begin Kindergarten (example: Fall 2019): ____________________

School Your Child Will Attend for Kindergarten: ______________________________

Parent/Guardian Legal Name: ______________________________________

Address: ____________________________________ City: _______________________, MI Zip: __________

Phone Number: ______________________ Email: ____

Medicaid: (please circle) Yes No

(If child has Medicaid, and is 3-6 years old, results will be forwarded to child's doctor.)

If your child has Medicaid, please fill out information below:
Medicaid Number: ______________________________
Primary Care Doctor: ______________________________
Doctor Address/City: ______________________________
Doctor Phone: ______________________________

HEARING HISTORY

1. Does your child have a programmable shunt?
   Yes **No**
2. Has child been seen by the doctor for any ear problems?
   Yes **No** If yes, date of last exam: ___/___/___
   Reason: ______________________________
   Name of Doctor: ________________________
3. As a parent/guardian, do you have any concerns regarding your child's hearing?
   Yes **No**
4. Is child currently on medication for a cold/allergies?
   Yes **No**

VISION HISTORY

1. Has child been examined by an eye doctor?
   Yes **No** If yes, date of last exam:___/___/___
   Reason: ______________________________
   Name of Eye Doctor: ______________________
2. As a parent/guardian, do you have any concerns regarding your child's vision?
   Yes **No**
3. When your child is ill or tired, do the eyes appear crossed or does one eye wander when looking at an object?
   Yes **No**

PLEASE DO NOT WRITE BELOW THIS LINE **PLEASE DO NOT WRITE BELOW THIS LINE**

Hearing Screening

_____ Preliminary Screening
_____ Intermediate Sweep
_____ Audiogram (see audiogram on file)

Comments:

Hearing Results

_____ Pass
_____ Refer
_____ Other (Under Care/Known Loss)
_____ Unable to Screen/Complete Screen
☐ Did Not Understand Screening Process
☐ Refused to Wear Headphones
☐ Communication Barrier

____
MDHHS Trained Hearing Technician

Vision Screening

1. Visual Acuity/2 Line Difference—LEA Symbols Cards

20/40		**20/25**	
Both Eyes	0 1 2 3 4 5 6		
Right Eye	0 1 2 3 4 5 6	Right Eye	0 1 2 3 4 5 6
Left Eye	0 1 2 3 4 5 6	Left Eye	0 1 2 3 4 5 6

2. Stereo Butterfly Test _____ Pass _____ Fail
3. Eye History _____ Pass _____ Fail
4. Symptom Referral _____ Pass _____ Fail
A N P S W N/O

Comments:

Vision Results

_____ Pass
_____ Refer
_____ Refer
☐ 2-Line Difference R / L
☐ 20/50
☐ Symptom
_____ Fail; Not Refer
☐ Under Care ☐ Permanent Difficulty
_____ Unable to Screen/Complete Screen
☐ Did Not Understand Screening Process
☐ Communication Barrier

____
MDHHS Trained Vision Technician