MONROE COUNTY HEALTH DEPARTMENT
PRE-KINDERGARTEN HEARING AND VISION RECORD

Appointment Date _____ Screening Site_____

Child's Name_____ Sex _____ Birthdate _____ Age _____

Address _____City _____Zip_____

Parent's /Guardian's names_____Phone_____

Race_____Primary Language_____Ethnicity_____

Does your child attend a pre-school program? _____ Where? _____

What school will child attend for kindergarten? _____

Child's physician _____ Physician's address_____

Please place a **check** in the box - ☐No Insurance ☐Private Health Insurance ☐Medicaid ID # _____

VISION

1. Has your child had a vision Screening? No_____ Yes_____
   Where?_____ Date?_____
2. Has your child ever been examined by an eye doctor?
   No_____ Yes _____ Date ?_____
   Eye doctor's name:_____
3. Does the doctor want to see him/her again?
4. Does your child wear glasses? No_____ Yes_____
5. Is he/she receiving any kind of eye treatment? No_____ Yes_____
   Treatment:_____
6. When your child is ill or tired, do the eyes appear crossed or does one eye wander when looking at an object?_____

HEARING

1. Has your child had a hearing test?_____
   Where?_____ Date ? _____
2. Has your child ever had:
   Earache? _____ Date? _____
   Running Ears? _____ Date? _____
   Ear Infections? _____ Date? _____
4. Is your child on medication now for a cold? _____
5. Is your child on medication now for the ears? _____
6. Operations: Tubes in ears _____ Date?_____
   Are tubes still in?_____
7. Does someone in the family have a hearing problem? _____
   Who? _____

I authorize the Health Department to perform Hearing & Vision screenings on my child.

_____

PARENT/GUARDIAN SIGNATURE ***DATE***

"Any child with an implanted medical device (e.g. digitally programmable shunts, pacemakers, Baclofen pumps, Vagus Nerve Stimulators, etc.) will not have a hearing screening due to the possibility of electromagnetic interference from the magnets in the audiometer headphones."

THIS SECTION –OFFICE USE ONLY

VISION RESULTS

Wears Glasses? Yes___ No___ Screened w/Glasses? Yes___ No____

Passed _____ Failed-Referred_____ UTS_____

Failed 2-Line Difference Only _____Fail-Not Referred _____
(Under Care)

Visual Acuity

	20/40	20/25	
Both	0 1 2 3 4 5 6		
Right	0 1 2 3 4 5 6	0 1 2 3 4 5 6→	☐ UTS
Left	0 1 2 3 4 5 6	0 1 2 3 4 5 6	

	Passed	Failed
The Stereo Butterfly Test	_____	_____
Eye History	_____	_____
Symptom (s)	_____	_____

Specify _____

Vision Technician _____

HEARING RESULTS

Screening Passed _____ Refer to Own Dr._____

UTS_____ Failed- Not Referred_____
(Under Care)

Audiogram: WNL_____

Other _____

Hearing Technician _____