MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

County Screening Location MEDICAID: Y N Number:

KINDERGARTEN ENTRY/PRESCHOOL HEARING AND VISION SCREENING RECORD

CHILD'S NAME _____ Male Female DOB _____ AGE _____

Name Used _____ School Attending _____

Primary Care Provider _____ Provider phone _____

PARENT/GUARDIAN'S NAME _____ Telephone _____ H/W/C

Address _____ City _____ Zip _____

BRIEF HISTORY

HEARING

1. Has your child been seen by a doctor for any ear problems? Y N
   Date of Exam _____ Doctor _____
2. Is your child on any cold or allergy medications? Y N
3. As a parent, do you have any concerns regarding your child's hearing? Y N

VISION

1. Has your child ever been examined by an eye doctor? Y N
   Date of Exam _____ Doctor _____
2. When your child is ill or tired, do the eyes appear crossed or does one eye wander when looking at an object? Y N

DO NOT WRITE BELOW THIS LINE

HEARING SCREENING

	Pass	Fail
Screening		
Threshold		
Audiogram		

RESULTS

- □ Pass
- □ Refer
- □ Under Care
- □ Retest

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	0 1 2 3 4 5 6
Left eye	0 1 2 3 4 5 6	0 1 2 3 4 5 6

2. Stereo Butterfly Pass Fail

3. Eye History Pass Fail

4. Symptom(s): _____ Pass Fail

RESULTS

- □ Pass
- □ Refer
  - □ 2-Line
  - □ 20/50
- □ Symptom
- □ Fail; no refer
- □ Under Care
- □ Permanent Difficulty
- □ Retest

ATTENTION PARENT(S): Your child was given the health department hearing and vision screening tests:

Hearing
- □ Passed
- □ Failed (an examination by your local health department or your doctor is required)

Vision
- □ Passed
- □ Failed (an eye examination by an ophthalmologist or optometrist is required)

Please present this certificate when enrolling your child in school for the first time (Michigan Public Health Code; Act 368 or 1978). Retain this statement with other health records of your child.

Child's Name Date of Screening Qualified Hearing/Vision Technician

Health Department

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