SIGHT & HEARING SCREENING

Parent/Guardian:
Please complete and return this form only if you want your student screened.

Signature: _____ Date: _____

Printed name: _____

Student's Name: _____ Age: _____ Sex: ☐ Female ☐ Male

Address: _____ Grade: ___

City: _____ State: ___ ZipCode: _____ Telephone: _____-_____-_____

Personal Data

Have you been seen by an eye doctor? □Yes □No
When? _____

Do you wear EYEGLASSES? □Yes □No
Date issued? _____

Do you have EAR DRAINAGE? □Yes □No

Are your eyeglasses for distance? □Yes □No
Are your eyeglasses for reading? □Yes □No
Do you wear CONTACT lenses? □Yes □No

Do you wear a HEARING AID? □Yes □No
Date issued? _____

THIS SECTION TO BE COMPLETED BY SCREENER

	500 Hz	1,000 Hz	2,000 Hz	4,000 Hz	6,000 Hz
RIGHT EAR					
LEFT EAR					

Hearing Test will be conducted at 20 DB & increased higher if necessary.

VISUAL ACUITY DISTANCE	RIGHT EYE	LEFT EYE
20/20		
20/30		
20/40		
20/50		
20/60		
20/70		
20/100		
OVER 20/100		

Results			
	Normal	**Abnormal**	**Needs Referral**
Hearing			
Vision			