LIVINGSTON COUNTY DEPARTMENT OF PUBLIC HEALTH

2300 E. Grand River, Suite 102 • Howell, MI 48843-7578 • (517) 546-9850

Screening Location: ____

Child's Legal Name: ____ Birthdate: ____________ Age: _____

Child's Nickname: ______________________ Parent/Guardian's Name: ________________________________

Address: ____________________________________ City: ______________________, MI Zip: ___________

Phone Number: ___________________________ School District: ____________________________________

Medicaid: (please circle) YES NO If yes, Medicaid # ____

BRIEF HEARING HISTORY

1. Has child been seen by a doctor for any ear problems? (please circle) YES NO
   If yes, when? __________ Reason:______________________________Name of Doctor: __________________
2. As a parent/guardian, do you have any concerns regarding your child's hearing? YES NO
   If yes, please describe: ____
3. Is child currently on medication for cold/allergies? YES NO If yes, name of medication: ____________________

BRIEF EYE HISTORY

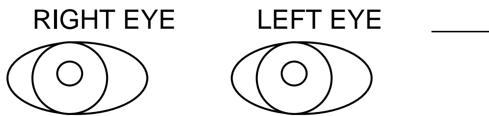
1. Has your child ever been examined by an eye doctor? YES NO
   If yes, when? ___________________ Name of eye doctor: ____
   Reason: ____
2. As a parent/guardian, do you have any concerns regarding your child's vision? YES NO
   If yes, please describe: ____
3. When your child is ill or tired, do his/her eyes appear crossed or does one eye wander when looking at an object? YES NO

PLEASE DO NOT WRITE BELOW THIS LINE

1. **VISUAL ACUITY**

20/40	Both eyes	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
20/25	Right eye	0	1	2	3	4	5	6
	Left eye	0	1	2	3	4	5	6

	PASS	DID NOT PASS
2. **CORNEAL REFLECTION**		
RIGHT EYE LEFT EYE	____	_____
3. **COVER-UNCOVER TEST – NEAR**		
Right Eye Movement	____	____
Left Eye Movement	____	____
COVER-UNCOVER TEST – FAR		
Right Eye Movement	____	____
Left Eye Movement	____	____
4. **EYE HISTORY**	____	____
5. **SYMPTOM REFERRAL**	____	____



HEARING RESULTS: ___ AuDx

___ Prelim ___ Intermediate Sweep

___ Audiogram (See audiogram for results)

- ___ Pass ___ Refer
- ___ Rescreen
- Date of Rscrn Appt: ___________
- ___ Unable to Screen
- ___ Unable to Complete Screen

Comments: ______________________________

____

VISION RESULTS:

- ___ Pass
- ___ Refer on: ___________________
- ___ Under Care
- ___ Permanent Difficulty
- ___ Unable to Screen
- ___ Unable to Complete Screen

Comments: ______________________________

____

Technician(s): __________________________

____

Date of Screening: ______________________