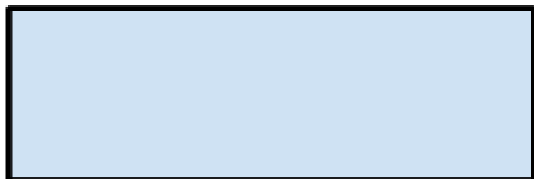
Vision and Hearing Screening



Date:

Vision Screening

Acuity Rt eye: Pass / Recheck   Color (Boys Only): Pass/Recheck

Acuity Lt eye: Pass/Recheck   Stereopsis: Pass/Recheck   Cover: Pass/Recheck

Wears Glasses: Yes/No   Comment (broken lost, poor condition): _________________

Recheck: Date: ___________   Acuity: RT: _______ Lt: ______ Ref Date: ________

Hearing:

RT ear: Pass (check only if heard)

1,000__________, 2,000_________, 4,000___________

LT. ear: Pass (check only if heard)

1,000__________, 2,000_________, 4,000___________

Recheck:
Threshold RT   1,000__________, 2,000_________, 4,000___________

Threshold LT   1,000__________, 2,000_________, 4,000___________

Ref Date: ________

Immunizations (circle): Complete/Incomplete/Exempt
Health Review:

Medications @ School:

Care Plan Given: Yes/No