EARLY CHILDHOOD VISION SCREENING WORKSHEET

NAME: | AGE: (YRS. / MO.) | SCREENING DATE: | RESCREEN DATE:

PARENT COMPLETES

VISION HISTORY QUESTIONS-All Ages

	NO	YES
1. Do you suspect anything is wrong with your child's eye/vision?		
2. Have the child's siblings, parents, grandparents, aunts, uncles or first cousins had eye/vision problems that required treatment before entering school?		
3. Have you observed any problems or change in the whites, pupils, lids, lashes or the area around the eyes?		
4. Have you noticed an abnormal sensitivity to light, nausea or dizziness or signs/complaints of headaches?		
5. Have you noticed any of the following?		
a. Turning of one eye (in, out, up or down)		
b. Poking at the eyes or frequent rubbing		
c. Poor eye contact		
d. Covering or closing an eye when looking at an item of interest		
e. Abnormal head posture		
f. Squinting		
g. Moving the head forward, backward or on the horizontal while looking at an item of interest		
h. Tilting the head to one side		
i. Placing the head close to an item of interest		
j. Excessive blinking		
k. Inaccurate reaching for an item of interest		
l. Unusual tearing		

NURSE COMPLETES

	SCREEN NO	SCREEN YES	RESCREEN NO	RESCREEN YES
Does child have glasses or contacts?				
Wearing them during screening?				
Problem Noted:				
A. Observation (6 months-3rd Grade)				
B. External Inspection (6 months and older) WIPL				
C. Corneal Light Reflection (6 months-3rd Grade)				
D. Cross Cover Test (6 months-3rd Grade) near & distant				
E. Visual Acuity (as early as possible)				

Screen: R 10/___ L 10/___

Rescreen: R 10/___ L 10/___

EARLY CHILDHOOD HEARING SCREENING WORKSHEET

NAME: | AGE: (YRS. / MO.) | SCREENING DATE: | RESCREEN DATE:

PARENT COMPLETES

HEARING HISTORY QUESTIONS-All Ages

1.	Is there concern that this child has a hearing problem?	Y	N
2.	Are there any hearing problems in the family of either the child's mother or father?	Y	N
3.	Does child have a history of middle ear disease and/or tubes?	Y	N
4.	Has child had serious head trauma with concussion, skull fracture or loss of consciousness?	Y	N
5.	Has child been hospitalized with a serious illness?	Y	N

NURSE COMPLETES

Problem Noted:	NO	YES
A. Risk Factors (29 days to 3 years)		
B. Hearing History (all ages)		
C. Visual Inspection/Otoscopy (all ages)		
D. Pure Tone (3 years)		

PURE TONE: Please note individual response in each box. Heard & Responds=✓ No Response=🚫

SCREEN: ☐ **HEAD COLD** ☐ **WNL** ☐ **RESCREEN**

Volume (dB)	20	20	20	25
Frequency (Hz)	1000	2000	4000	500
Right Ear				
Left Ear				

RESCREEN: ☐ **HEAD COLD** ☐ **WNL** ☐ **RESCREEN**

Volume (dB)	20	20	20	25
Frequency (Hz)	1000	2000	4000	500
Right Ear				
Left Ear				

RELIABILITY: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**