SHEBOYGAN AREA
SCHOOL DISTRICT

Hearing and Vision Screening Request

Vision screenings for PK, K4, 1st, 3rd & 5th grades will be conducted in the fall of each school year. Additional vision screenings can be requested for elementary students at any time. For middle and high school students, vision concerns will be addressed by automatically sending a vision referral to the parents to consult an eye care provider. Hearing screenings are available upon request for all grade levels on an individual basis. Please be sure to check the Skyward health tab to see if the student has been recently screened, or has any known vision or hearing concerns.. If you would like to refer a student for a screening, please complete the necessary information below and forward it to Dianna Latsch at ELC.
Important Note: *Screenings will not be conducted during the first or last four weeks of the school year.*

Date: ______________________________ Student ID # ______________________

Student's Name: ____

School: ________________________________ Grade: ______________________

Staff member making referral: ____

I am requesting the above student be screened for __________________________________
(Hearing/Vision/Both)

Please check the symptoms of **hearing** loss the student is exhibiting:

_____ I need to raise my voice to get the student's attention
_____ Student frequently says "huh? or what?" when someone is speaking
_____ Student has a history of ear infections/earaches/runny ears
_____ Student turns head toward the sound source or watches the speaker's mouth carefully
_____ Student prefers either very low or very high pitched sounds
_____ Student talks in a loud or soft voice
_____ Student turns the radio or television up
_____ Student does not always come or look when called upon
_____ Student's speech is poorer than you would expect for a child that age
_____ Student is inattentive or asks to have words repeated frequently
_____ Other ____

Results: Right Ear_____________ Left Ear ____________ Date ____________
Rescreen Results: Right Ear ____________ Left Ear ____________ Date ____________

Please check the symptoms of a **vision** loss the student is exhibiting:

_____ Student rubs eyes excessively
_____ Student is unable to see the board
_____ Student blinks frequently
_____ Student holds a book 7" or less
_____ Student omits letters/words
_____ Student complains of blurred vision
_____ Student loses place while reading
_____ Student complains of headaches
_____ Student reverses letters (b for d)
_____ Student fatigues easily
_____ Student has a short attention span
_____ Student dislikes or avoids close work
_____ Student squints for either near or far tasks
_____ Student turns head to use only one eye
_____ Student covers/closes one eye while reading
_____ Student moves head back/forth when reading
_____ Student omits "small" words
_____ Student complains of double vision
_____ Student uses a finger to keep place
_____ Student writes uphill or downhill
_____ Student skips or rereads words while reading
_____ Student complains of burning or itching eyes
_____ Student has difficulty remembering what is read
_____ Student has poor hand-eye coordination
_____ Student has difficult-to-read handwriting, is crowded or inconsistent in size
_____ Other ____

Results: Right Eye ______________ Left Eye ____________ SPOT results ____________

DL 031025