BERRIEN COUNTY HEALTH DEPARTMENT
PRESCHOOL/KINDERGARTEN HEARING AND VISION FORM

CHILD'S LEGAL NAME _____ BIRTHDATE _____ AGE _____

HOME ADDRESS _____ CITY _____ ZIP _____ PHONE _____

CHILD'S PRIMARY LANGUAGE ☐ ENGLISH ☐ OTHER _____ ☐ MALE ☐ FEMALE

ATTENDING KINDERGARTEN AT _____
SCHOOL

BRIEF HEARING HISTORY

1. **Does your child have a shunt?** ☐ YES ☐ NO
2. Has your child been to a doctor for **any** ear problems? ☐ YES ☐ NO
3. Is child on medication for cold/allergies? ☐ YES ☐ NO
4. Does your child have a known hearing loss? ☐ YES ☐ NO
5. If you have any concerns regarding your child's hearing, please explain: _____

_____

BRIEF EYE HISTORY

1. Has your child ever been to an **EYE** doctor? ☐ YES ☐ NO Reason _____
2. Does your child wear glasses? ☐ YES ☐ NO
3. When your child is ill or tired, do their eyes cross or one eye wander? ☐ YES ☐ NO
4. Has your child ever had eye surgery? ☐ YES ☐ NO

I. Visual Acuity

Both eyes	0	1	2	3	4	5	6
20/40 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
20/50 Right eye	0	1	2	3	4	5	6
Left eye	0	1	2	3	4	5	6

VISION RESULTS

PASSED PERM. DIFFICULTY GLASSES UNABLE TO SCREEN

REFERRED ON _____

TECHNICIAN _____

	PASSED	FAILED
II. Stereo Butterfly	_____	_____
III. Eye History	_____	_____

IV. Symptom Referral A N P S W N/A

HEARING RESULTS

PASSED REFERRED UNDER CARE UNABLE TO SCREEN RESCREEN

RIGHT	1000	2000	4000
LEFT	1000	2000	4000

TECHNICIAN _____

Berrien County Printing