REGION 9 EDUCATION SERVICE CENTER
WICHITA FALLS TEXAS

HEARING/VISION SCREENING FOR THREE (3) YEAR OLD STUDENTS

To be used if child is un-testable

NAME: _____ **DATE OF TESTING:** _____

DOB: _____ **DISTRICT:** _____

STAFF MEMBER CONDUCTING SCREENING: _____

PARENT/GUARDIAN PROVIDING INFORMATION: _____

VISION SCREENING

	YES	NO	
1.	___	___	Formal vision testing by doctor/eye specialist? Name of doctor: _____ Date: _____
2.	___	___	Does the parent suspect any problems with vision?
3.	___	___	Does the child squint, close, or cover one eye?
4.	___	___	Does the child move his/her head forward or backward when looking at near/distant objects?
5.	___	___	Does the child tilt his/her head to one side?
6.	___	___	Do the child's eyes turn inward/outward?
7.	___	___	Can the child track/follow moving objects around the room?

HEARING SCREENING

1.	___	___	Formal hearing testing by doctor/ENT? Name of doctor: _____ Date:_____
2.	___	___	Tubes in ears? Date of surgery: _____
3.	___	___	Does the parent suspect a hearing loss? Which ear? _____
4.	___	___	Has the child had a history of frequent ear infections?
5.	___	___	Does the child respond to a familiar voice when that person is out of the room or out of sight?
6.	___	___	Does the child discriminate between different sounds (telephone, doorbell, loud/soft voices)?

COMMENTS _____