

Hearing and Vision Services
734-240-7855

Dear Parent:

Hearing and vision defects go undetected by parents in eight out of ten pre-school children. Good hearing and vision are necessary for normal development, and even a mild defect may result in educational difficulty and behavior problems. Early detection of these defects may prevent permanent damage.

The State of Michigan requires all children entering kindergarten to have their hearing and vision screened at least once between the age of 3 and 5. The Monroe County Health Department is making available to you both hearing and vision screening services for your preschool children **three to five years of age**. This program is provided without cost and will be held at the:

MONROE COUNTY HEALTH DEPARTMENT

Appointments are necessary

Please call to schedule an appointment (734-240-7905) or complete and return the lower half of this form to the Health Department and a Hearing and Vision representative will contact you.

To have a Hearing & Vision representative contact you to schedule an appointment please

Return to: Monroe County Health Department Hearing and Vision Services
2353 S. Custer Rd., Monroe, MI 48161

PLEASE PRINT

Child's Name _____ Birthdate _____

Child's Name _____ Birthdate _____

Parents'/Guardians' Names _____

Address _____ Apt./Lot # _____

City _____ Zip _____

Telephone: Home _____ Cell _____ Work _____

HV305
bd:rev:10/2013

****CHILD WILL NOT BE SCREENED IF THIS FORM IS NOT SIGNED****

MONROE COUNTY HEALTH DEPARTMENT
PRE-KINDERGARTEN HEARING AND VISION RECORD
(TO BE COMPLETED BY PARENT OR GUARDIAN ONLY)

Appointment: _____ Screening Site: _____
Child's Name: _____ Sex: _____ Birth Date: _____ Age: _____
Address: _____ City: _____ Zip: _____
Parent's /Guardian's Names: _____ Phone: _____
Race _____ Primary Language: _____ Ethnicity: _____
Does your child attend a pre-school program? _____ Where? _____
What school will child attend for kindergarten? _____
Child's Physician: _____ Physician's Address: _____
Please Place a Check in the Box - No Insurance Private Health Insurance Medicaid ID # _____

VISION

1. Has your child had a vision screening? _____
Where? _____ Date? _____
2. Has your child ever been examined by an eye doctor?
No _____ Yes _____ Date? _____
3. Does the doctor want to see him/her again? _____
Eye doctor's name: _____
4. Does child wear glasses? _____
5. Is he/she receiving any kind of eye treatment? _____
6. At any time have you noticed your child's eyes to appear
crossed, turning in or turning out? _____

I authorize the Health Department to perform Hearing & Vision screenings on my child.

HEARING

1. Has your child had a hearing test? _____
Where? _____ Date? _____
2. Has your child ever had:
Earache? _____ Date? _____
Running Ears? _____ Date? _____
Ear Infections? _____ Date? _____
3. Is your child on medication now for a cold? _____
4. Is your child on medication now for the ears? _____
5. Operations: Tubes in ears _____ Date? _____
Are tubes still in? _____
6. Does someone in the family have a hearing problem? _____
Who? _____

Enter Additional Ear History on Reverse Side.

****PARENT / GUARDIAN SIGNATURE**** _____ **DATE** _____

*****DO NOT WRITE BELOW THIS LINE*****

VISION RESULTS

Passed _____ Failed 2 Line Difference Only _____

Failed-Not Referred _____ Failed-Referred _____

Visual Acuity:

	20/40	20/25								
Both	<table border="1"><tr><td>0</td><td>1</td><td>2</td><td>3</td></tr></table> 4 5 6	0	1	2	3	<table border="1"><tr><td>0</td><td>1</td><td>2</td><td>3</td></tr></table> 4 5 6	0	1	2	3
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0	1	2	3							
0	1	2	3							

HEARING RESULTS

Passed Screening _____ Failed Screening _____

Passed Threshold _____ Failed Threshold _____

Normal Audiogram _____

Referral _____

Other _____

Impedance: R _____ L _____

Hearing Technician _____

COVER-UNCOVER TEST

	PASSFD	FAILED
Right Eye-Near	_____	_____
Left Eye-Near	_____	_____
Right Eye-Far	_____	_____
Left Eye-Far	_____	_____
Vision Technician	_____	_____

	PASSED	FAILED
Corneal Reflection	_____	_____
Eye History	_____	_____
Symptom (s)	_____	_____
Specify:	_____	_____