Health and Community Services
Health Department

Hearing and Vision Program

FOR TECHNICIAN ONLY
Date: _____ / _____ / _____
Location: _____
_____

Hearing: P F O NS
Vision: P F O NS
MA: ____ HK-EXP: _____
MICHILD: ____ NO BILL: _____

Child's Legal Name: _____

☐ Male ☐ Female Birthdate: _____ / _____ / _____ Age: _____

Year Your Child Will Begin Kindergarten (example: Fall 2024): _____

School Your Child Will Attend for Kindergarten: _____

Parent/Guardian Legal Name: _____

Address: _____ City: _____ MI Zip: _____

Phone Number: _____ Email: _____

Medicaid: ☐ Yes ☐ No
(If child has Medicaid, and is 3-6 years old, results will be forwarded to child's doctor.)

If your child has Medicaid, please fill out information below:
Medicaid Number: _____
Primary Care Doctor: _____
Doctor Address/City: _____

HEARING HISTORY

1. Does your child have a programmable shunt?
   ☐**Yes** ☐**No**
2. Has child been seen by the doctor for any ear problems?
   ☐**Yes** ☐**No** If yes, date of last exam: ___/___/___
   Reason: _____
   Name of Doctor: _____
3. As a parent/guardian, do you have any concerns regarding your child's hearing?
   ☐**Yes** ☐**No**
4. Is child currently on medication for a cold/allergies?
   ☐**Yes** ☐**No**

VISION HISTORY

1. Has child been examined by an eye doctor?
   ☐**Yes** ☐**No** If yes, date of last exam:___/___/___
   Reason: _____
   Name of Eye Doctor: _____
2. As a parent/guardian, do you have any concerns regarding your child's vision?
   ☐**Yes** ☐**No**
3. When your child is ill or tired, do the eyes appear crossed or does one eye wander when looking at an object?
   ☐**Yes** ☐**No**

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

Hearing Screening

_____ Preliminary Screening
_____ Intermediate Sweep
_____ Audiogram (see audiogram on file)
Comments:

Hearing Results

_____ Pass
_____ Refer
_____ Other (Under Care/Known Loss)
_____ Unable to Screen/Complete Screen
☐ Did Not Understand Screening Process
☐ Refused to Wear Headphones
☐ Communication Barrier

_____
MDHHS Trained Hearing Technician

Vision Screening

1. Visual Acuity/2 Line Difference—LEA Symbols Cards

20/40

Both Eyes	0	1	2	3	4	5	6
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

RX: GL CL N/A

2. Stereo Butterfly Test _____ Pass _____ Fail
3. Eye History _____ Pass _____ Fail
4. Symptom Referral _____ Pass _____ Fail
A N P S W N/A

Comments:

Vision Results

_____ Pass
_____ Refer
_____ Refer
☐ 2-Line Difference R / L
☐ 20/50
☐ Symptom
_____ Fail; Not Refer
☐ Under Care
☐ Permanent Difficulty
_____ Unable to Screen/Complete Screen
☐ Did Not Understand Screening Process
☐ Communication Barrier

_____
MDHHS Trained Vision Technician