Privacy Notice (04-14-03) given: _____

LIVINGSTON COUNTY
Health Department

2300 E. Grand River Ave., Suite 102 • Howell, MI 48843-7578 • (517) 546-9850

Screening Location: _____ School District: _____

Child's Legal Name: _____ Birthdate: _____ Age: _____

Parent/Guardian's Name: _____ Phone Number: _____

Address: _____ City: _____, MI Zip: _____

Medicaid: (please circle) **Yes** **No** If yes, Dr.'s Name _____

(If child has Medicaid, and is 3-6 yrs old, results will be forwarded to child's Doctor.)

Dr.'s Address/City _____

Dr.'s Phone: _____

BRIEF HEARING HISTORY

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

BRIEF EYE HISTORY

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

(If your child confuses colors or a family member has a Color Vision Deficiency, please discuss with your child's doctor. The vision screening performed does not check for Color Vision Deficiency.)

-- PLEASE DO NOT WRITE BELOW THIS LINE --

HEARING SCREENING RESULTS:

___ Pass Preliminary Screen

___ Pass Intermediate Sweep

___ Did not Pass – To be Rescreened

Tones Missed: _____

Date of Rscrn Appt: _____

___ Unable to Screen/Complete Screen

___ Audiogram (See audiogram for details)

___ Pass

___ Refer

___ Other (Under Care/Known Loss)

Comments: _____

_____

Technician: _____

Date of Screening: _____

1. VISUAL ACUITY – LEA SYMBOLS CARDS

20/40	Both Eyes	0	1	2	3	4	5	6	*(20/50)*
	Right Eye	0	1	2	3	4	5	6	R -
	Left Eye	0	1	2	3	4	5	6	L -
20/25	Right Eye	0	1	2	3	4	5	6	
	Left Eye	0	1	2	3	4	5	6	

2. **STEREO BUTTERFLY TEST - Near:** PASS FAIL

3. **EYE HISTORY** PASS FAIL

4. **SYMPTOM REFERRAL** PASS FAIL

A N P S W N/A

VISION SCREENING RESULTS:

___ Pass Rx: Glasses Contacts N/A

___ Refer on: _____

___ FNR -- Permanent Difficulty

___ Unable to Screen/Complete Screen

Comments: _____

Technician: _____ Date: _____

3-30-17