VISION AND HEARING SCREENS

Agency Program Name: ______________________________ KIDS Child ID# _____________________

Child’s Legal First Name _____________________ Legal Last Name ______________________________

1. Date Vision Screen Completed: _____/_____/_______ MM/DD/YYYY

2. As a result of this vision screening, was a recommendation for further assessment or services provided to the parent(s)? (If yes, complete question #5)
   ○ Yes  ○ No

3. If yes in question 4, did the family access recommended services for this child? (If no, complete #6)
   ○ Yes  ○ No

4. If no in question 5, check all of the following that apply:
   ○ Family declined further services.
   ○ Family opts out for religious or other medical reasons.
   ○ Family lacks access to services (i.e. distance for treatment, lack of transportation, etc.)
   ○ Additional testing is cost prohibitive.
   ○ Other __________________________________________________________

5. Date Hearing Screen Completed: _____/_____/_______ MM/DD/YYYY

6. As a result of this hearing screening, was a recommendation for further assessment or services provided to the parent(s)? (If yes, complete question #5)
   ○ Yes  ○ No

7. If yes in question 4, did the family access recommended services for this child? (If no, complete #6)
   ○ Yes  ○ No

8. If no in question 5, check all of the following that apply:
   ○ Family declined further services.
   ○ Family opts out for religious or medical reasons.
   ○ Family lacks access to services (i.e. distance for treatment, lack of transportation, etc.)
   ○ Additional testing is cost prohibitive.
   ○ Other __________________________________________________________