# NWCA Head Start/Early Head Start
# Vision Screening Worksheet

| Child's Name | Age (Yrs/Mo) | Screening Date | Rescreen Date |
|---|---|---|---|
| | | | |

## VISION HISTORY AND QUESTIONS – ALL AGES

| | YES | NO |
|---|---|---|
| 1. Do you suspect anything is wrong with your child's eye/vision? | | |
| 2. Have the child's siblings, parents, grandparents, aunts, uncles, or first cousins had eye/vision problems that required treatment *before entering school*? | | |
| 3. Was the child born premature or had retinopathy of prematurity? | | |
| 4. Is there a family history of congenital cataracts, retinoblastoma, metabolic or significant development delay? | | |
| 5. Have you observed any problems or change in the whites, pupils, lids, lashes or the area around the eyes? | | |
| 6. Have you noticed an abnormal sensitivity to light, nausea or dizziness or signs/complaints of headaches? | | |
| 7. Do both of the child's eyes appear the same in pictures? | | |
| 8. Have you noticed any of the following: | | |
| a. Turning of one eye (in, out, up or down)? Either occasional or always. | | |
| b. Poking at the eyes or frequent rubbing? | | |
| c. Poor eye contact? | | |
| d. Covering or closing an eye when looking at an item of interest? | | |
| e. Squinting, blinking or unusual tearing? | | |
| f. Inaccuracy in reaching for item of interest? | | |

## VISION SCREENING

**Spot Vision Screener** ☐ **Pass** ☐ **Refer**

| | SCREEN | | RESCREEN | |
|---|---|---|---|---|
| | YES | NO | YES | NO |
| Does child have glasses or contacts? | | | | |
| Wearing them during screening? | | | | |
| **Problem Noted:** | | | | |
| A. External Inspection (Birth and older) WIPL | | | | |
| B. Observation (2 months – 3rd grade) | | | | |
| C. Corneal Light Reflection (2 months – 3rd grade) | | | | |
| D. Cross Cover Test (4months – 3rd grade) | | | | |
| E. Visual Acuity (age 3 as early as possible) | | | | |
| **age 3-5 yr Screen R 10/_____ L 10/_____** | | | | |
| **Re-Screen R 10/_____ L 10/_____** | | | | |
| F. EOM/Fix and Follow Binocular (2 months until V.A.) | | | | |
| G. EOM/Fix and Follow Monocular (2 months until V.A.) | | | | |
| H. Pupillary Light Response (birth until V.A.) | | | | |
| I. Retinal Reflex (birth until V.A.) | | | | |

# NWCA Head Start/Early Head Start
# Hearing Screening Worksheet

| Child's Name | Age (Yrs/Mo) | Screening Date | Rescreen Date |
|---|---|---|---|
| | | | |

## HEARING HISTORY – ALL AGES

| | YES | NO |
|---|---|---|
| 1. Is there a concern that this child has a hearing problem? | | |
| 2. Are there any *childhood hearing* problems in the family of either the child's mother or father? | | |
| 3. Does the child have a history of middle ear disease and/or tubes? | | |
| 4. Has the child had a head trauma with concussion, skull fracture or loss of consciousness? | | |
| 5. Has the child ever been hospitalized with a serious illness (i.e. kidney, meningitis)? | | |

## HEARING SCREENING

| | SCREEN | | RESCREEN | |
|---|---|---|---|---|
| | YES | NO | YES | NO |
| **OAE** | | | | |
| **Problem Noted:** | | | | |
| A. External Inspection | | | | |
| B. Internal Inspection/Otoscopy (all ages) | | | | |

## PURE TONE: [Note: WNL = Within Normal Limits]

**Screen:** ☐ Head Cold ☐ WNL ☐ Rescreen

| Level (dB) | 25 | 20 | 20 | 20 |
|---|---|---|---|---|
| Frequency (Hz) | 500 | 1000 | 2000 | 4000 |
| Right Ear | | | | |
| Left Ear | | | | |

**Re-Screen:** ☐ Head Cold ☐ WNL ☐ Rescreen

| Level (dB) | 25 | 20 | 20 | 20 |
|---|---|---|---|---|
| Frequency (Hz) | 500 | 1000 | 2000 | 4000 |
| Right Ear | | | | |
| Left Ear | | | | |