SCHOOL VISION AND HEARING CONSENT AND RECORD

PARENTS, PLEASE COMPLETE THE TOP HALF, SIGN AND RETURN TO YOUR CHILD'S TEACHER.

CHILD MUST HAVE SIGNED CONSENT TO BE SCREENED.

Student's Name_____ Parent's Name _____

Last First MI Last First

Address_____ City_____ Phone (Home)_____ (Work)_____

Birthdate_____ Grade_____ School_____ Teacher_____

Vision and hearing Screening is a service provided by Pittsville Elementary School.

I request my child participate in the screening programs. (Please check and sign).

(**4K-8**) Vision Yes___ No___ (**5K-3**) Hearing Yes___ No___

CLOSE VISION ASSESSMENT: Has your child complained of, or have you noted any of the following?

Do symptoms occur even if wearing his/her glasses?

	Yes	No		Yes	No
Frequent Headaches?			Closing or covering one eye while reading?		
Blurring of distant objects?			Blurring of print while reading?		
Holding a book closer than 12 inches?			One eye turning in or out at any time?		
Seeing objects double?			Does your child wear glasses?		
Does your child see an eye doctor?					

Who is your child's eye doctor?_____ When is the next appointment?_____

Date of last appointment?_____

Other concerns? _____

Checking one or more of these complaints for your child in the 'yes' column could be a significant sign of close vision problems. Please have your child's eyes examined by an eye doctor.

Signature of parent or guardian_____

FOR SCHOOL USE - FILED IN PERMANENT HEALTH RECORD

Check if child is wearing glasses/contacts **O**

Check if child has glasses but is not wearing them **O** Reason for not wearing glasses_____

Date: _____	Date:_____	Date:_____
Distance Vision Screening	Distance Vision Re-Screening	Hearing Screening
Right Eye-20/	Right Eye-20/	O Pass right O Pass left
Left Eye-20/	Left Eye-20/	O Re-screen
Both eyes- 20/	Both eyes- 20/	Date:_____
		Hearing Re-Screen
Pass O Re-Screen O	Pass O Refer O	Pass O Refer O

Screening Comments: _____

_____

Date referral sent to parent:_____

Nurse Follow-up:_____

Signature of Nurse_____ Date_____

Vision Screening: Grades 4K, K, 1, 2, 3, 4, 5, and 6 your child will be screened for distance vision loss. This program is offered in the fall of the year in order to pick up any problems that may affect learning. Parents are notified by letter if their child shows a possible vision loss. *Screening does not include close vision testing.* Screening is not a substitute for complete professional eye care. Other grades may be tested with a written request to the school.

Hearing Screening: The hearing screening program is conducted in the fall of the year and is coordinated with the vision program. Trained volunteers screen students in grades 5K, 1, 2, and 3. Those students showing possible hearing loss are retested. A letter will notify parents if follow-up care is needed.

Screener notes:

Date of Hearing Re-screening:_____ Screener:_____

Pure Tone Rescreening – Circle Child's Non Response Level

	1000 HZ	2000 HZ	3000 HZ	4000HZ	4000 HZ
R	20 dB	20 dB	20 dB	20 dB	25 dB
L	20 dB	20 dB	20 dB	20 B	25 dB

Recommendations - PHN to complete

O Pass - No further action required

O Refer for medical or audiological evaluation

O Retest next year if failure at 4000 HZ only in one or both ears. If in third grade, retest between March 1st - April 30th.