Northwestern Ohio Community Action Commission
HEAD START
Guiding Children and Families Toward Success

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Defiance, OH 43512
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Hearing and Vision Screening Results Form

Please find attached the hearing and vision screenings performed by Head Start/Early Head Start staff. No further action is needed unless indicated.

_____ _____ _____
Participant's Name | Date of Birth | Date of Screen

_____ _____
Classroom | Site

Hearing Screen

____ First Screening **____ Second Screening**

- ☐ **PASS**
- ☐ **FAIL**
  - ☐ Concern with **Left**, **Right**, or **Both** (circle one).
  - ☐ Referral letter given.
  - ☐ **UNABLE TO TEST** (Circle one: *Hearing Aids* or *Tubes*) ***(Complete ROI)***
- ☐ **PARENT REFUSED PERMISSION** – Not screened. ***(Waiver must be completed.)***
- ☐ **ATTEMPTED**: Needs re-screened due to _____.
- ☐ **ABSENT** day of screening.

Vision Screen

- ☐ **PASS**
- ☐ **FAIL**
  - ☐ Referral letter given.
  - ☐ **UNABLE TO TEST**: Wears glasses. ***(Complete ROI)***
- ☐ **PARENT REFUSED PERMISSION** – Not screened. *(Waiver must be completed.)*
- ☐ **ATTEMPTED**: Needs re-screened due to _____.
- ☐ **ABSENT** day of screening.

Screened by:_____
(Write legibly)

White- CO Yellow- Participant's File Pink- Parent/Guardian