**BRIEF HEARING HISTORY**

1. Does your child have a shunt or ANY other medically implanted device? □ YES □ NO
2. Has your child been to a doctor for any ear problems? □ YES □ NO
3. Is child on medication for cold/allergies? □ YES □ NO
4. Does your child have a known hearing loss? □ YES □ NO
5. If you have any concerns regarding your child's hearing, please explain:

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**BRIEF EYE HISTORY**

1. Has your child ever been to an EYE doctor? □ YES □ NO   Reason __________________________________________________________
2. Does your child wear glasses? □ YES □ NO
3. When your child is ill or tired, do their eyes cross or one eye wander? □ YES □ NO

---

**VISION RESULTS**

<table>
<thead>
<tr>
<th>20/40 Right eye</th>
<th>20/40 Left eye</th>
<th>20/25 Right eye</th>
<th>20/25 Left eye</th>
<th>20/50 Right eye</th>
<th>20/50 Left eye</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
</tr>
</tbody>
</table>

PASSED        PERM. DIFFICULTY        UNABLE TO SCREEN

GLASSES

**HEARING RESULTS**

<table>
<thead>
<tr>
<th>Right</th>
<th>1000</th>
<th>2000</th>
<th>4000</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEFT</td>
<td>1000</td>
<td>2000</td>
<td>4000</td>
</tr>
</tbody>
</table>

**DO NOT WRITE BELOW THIS LINE**