

The following form(s) can be filled in on-line, then printed for signatures and mailing or faxing.

To begin filling out the forms in Acrobat Reader, make sure the **hand** tool is selected then click on a line or in a box and begin typing. Check boxes can be clicked on or off.



Spokane County Head Start/ECEAP/EHS

SENSORY/GROWTH SCREENING RESULTS

Child's name _____ Site and room no. _____

GROWTH ASSESSMENT

DATE	HEIGHT	WEIGHT	OFC (0-24M)	STAFF INITIALS
1 / /				
2 / /				

HEARING SCREENING

Date ____/____/____ OAE: Pass Refer Unable to screen (UAT) (only use UAT within first 45 days)

Staff initials _____ Reason for UAT _____

Repeat screening due to: UAT MD recommended follow-up screening after a referral
 Failed first screen

Date ____/____/____ OAE: Pass Refer Date ____/____/____ OAE: Pass Refer

Staff initials _____ Staff initials _____

VISION SCREENING

STEP #1 Check all that apply:

- Wears glasses. (Do not screen—send for results) Date of last eye exam ____/____/____
- Parent has concern _____
- None of the above

STEP #2

- Sure site Date ____/____/____
- Photo screener Date ____/____/____

staple results

STEP #3 Eye Alignment/Strabismus (Needed for Sure sight) No concern Concern

- Unable to test Reason _____

STEP #4

Vision screen results: Pass Refer Staff initials _____

SCREENING RESULTS DISCUSSED AND/OR GIVEN TO PARENT.

Staff signature _____ Date ____/____/____

INFANT/TODDLER HEARING AND VISION SCREENING (generally 0-6 months)

Child's name _____ Birth date _____

HEARING SCREENING

Person doing screening _____ Date of screening ____/____/____ Site _____

Person doing screening _____ Date of screening ____/____/____ Site _____

HEARING SCREENING TABLE

EAR	NOISEMAKER	DISTANCE	0-5 MONTHS		6-24 MONTHS	
Right Ear	Egg Rattle	3 feet (90 cm.)			Pass	Fail
Left Ear	Squeeze Toy	3 feet (90 cm.)			Pass	Fail
Right Ear	Bell	3 feet (90 cm.)			Pass	Fail
Left Ear	Key Rattle	3 feet (90 cm.)			Pass	Fail
Right Ear	Horn	3 feet (90 cm.)	Pass	Fail	Pass	Fail
Left Ear	Horn	3 feet (90 cm.)	Pass	Fail	Pass	Fail

VISION SCREENING

Person doing screening _____ Date of screening ____/____/____ Site _____

Person doing screening _____ Date of screening ____/____/____ Site _____

<input type="checkbox"/> NEWBORN-6 MONTHS (ITEMS 1 and 5 ONLY)	<input type="checkbox"/> 6 MONTHS-3 YEARS (ITEMS 1 through 5)	YES	NO
1. History for Risk Factors: (e.g., maternal rubella, family history of vision problems, supplement oxygen therapy for premature infants, etc.)			
2. Pupillary Response to Light			
3. Ability to Fixate and Track a Moving Object			
4. Strabismus – (Hirschburg and Cover Test): <input type="checkbox"/> Pass <input type="checkbox"/> Fail			
5. Vision-related Signs and Symptoms: (Check all those that pertain and/or describe signs and symptoms)			
<input type="checkbox"/> Squinting <input type="checkbox"/> Closing one eye <input type="checkbox"/> Rubbing eyes <input type="checkbox"/> Inattention or excessive attention			
<input type="checkbox"/> Structural concern <input type="checkbox"/> Alignment concern			
<input type="checkbox"/> Other (please describe): _____ _____ _____			
PASSED VISION SCREEN <input type="checkbox"/> YES <input type="checkbox"/> NO			