Community Colleges of Spokane

Spokane County Head Start/ECEAP/EHS SENSORY/GROWTH SCREENING RESULTS

Reset Form

Child's last name _____ Site and room no. _____

GROWTH ASSESSMENT

DATE	HEIGHT	% HT/AGE	WEIGHT	%WT/AGE	%WT/HT	BMI/HC	STAFF
1.							
2.							

1. ☐ Discussed with parent Date _____ 2. ☐ Discussed with parent Date _____

HEARING SCREENING

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

Reason for UAT _____ Staff initials _____

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

Date _____ OAE: ☐ Pass ☐ Refer Date _____ OAE: ☐ Pass ☐ Refer

Staff initials _____ ☐ Discussed with parent

VISION SCREENING

STEP #1 Check all that apply:

☐ Wears glasses. (Do not screen—send for results) Date of last eye exam _____
☐ Parent has concern (explain)

_____

☐ Did not screen - made referral based on parent's concern
☐ Sees eye doctor regularly (Do not screen—send for current exam)
☐ None of the above

STEP #2		
Sure site Date _____	Photo screener Date _____	**Staple results/Photo**

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 _____

STEP #5

☐ Discussed with parent Staff initials _____

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

Child's last 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 _____

☐ **NEWBORN-6 MONTHS (ITEMS 1 and 5 ONLY)**	☐ **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): ☐ **Pass** ☐ **Fail**			
5. Vision-related Signs and Symptoms (Check all those that pertain and/or describe signs and symptoms)**:** ☐ Squinting ☐ Closing one eye ☐ Rubbing eyes ☐ Inattention or excessive attention ☐ Structural concern ☐ Alignment concern ☐ Other (please describe): _____ _____			
PASSED VISION SCREEN ☐ **YES** ☐ **NO**			