Student Vision and Hearing Screening Record

Student Information

Student Full Name:		Date of Birth:	MM/DD/YYYY
Grade:		School:	
Date of Screening:	MM/DD/YYYY	Examiner Name/Title:	

Vision Screening

Test Category	Right Eye (OD)	Left Eye (OS)	Both Eyes (OU)
Without Correction (Acuity)	20 /	20 /	20 /
With Correction (Glasses/Contacts)	20 /	20 /	20 /

Were glasses/contacts worn during testing? (Enter Yes or No):

Vision Screening Result (Enter Pass, Fail, or Refer):

Hearing Screening

Pure Tone Audiometric Threshold (Enter dB level or "Pass"/"Fail" for each frequency):

Ear	1000 Hz	2000 Hz	4000 Hz
Right Ear			
Left Ear			

Hearing Screening Result (Enter Pass, Fail, or Refer):

Notes and Recommendations

Comments / Recommendations for Follow-up:

Examiner Signature: Date: