

**HEALTH SCREENING RESULTS  
FOR PARENT/GUARDIAN**

CHILD'S NAME \_\_\_\_\_

SCREENING DATE \_\_\_\_\_

The screenings checked below were performed with your child. The results of the screenings are noted.

\_\_\_\_\_ **HEARING**

\_\_\_\_\_ Passed

\_\_\_\_\_ Your child will be re-screened by Head Start on another day.

\_\_\_\_\_ Your child's ears need to be checked by a doctor as soon as possible.

\_\_\_\_\_ Your child's hearing needs to be evaluated further at the  
Speech and Hearing Clinic.

\_\_\_\_\_ **VISION**

\_\_\_\_\_ Passed

\_\_\_\_\_ Your child's vision will be re-tested by Head Start.

\_\_\_\_\_ Your child's vision needs to be checked by an eye doctor.

Referrals made: \_\_\_\_\_

\_\_\_\_\_

\*\*If your child was referred for further evaluation, your Family Partnership Assistant will contact you soon to determine your plan for follow-up and provide assistance, if needed.