Initial Evaluation
Vision and Hearing Screening

Student Name:____ Date of Birth:____________________

District:______________________________________ School: _____________________________________

VISION

Passed________________

Failed_________________

Date__________________

RECHECKED

Passed________________

Failed_________________

Date__________________

REFERRED

_____ Yes; Referred to:

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_____ No; Reason:____________

____

Date_________________________

COMMENTS:

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Screening Technician

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Date

HEARING

Passed________________

Failed_________________

Date__________________

RECHECKED

Passed________________

Failed_________________

Date__________________

REFERRED

_____ Yes; Referred to:

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_____ No; Reason:______________

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Date___________________________

COMMENTS:

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Screening Technician

____
Date

Form C11