



## Vision and Hearing Screening Consent 2011-2012

Dear Parent/Guardian,

Within the next few weeks, we will be visiting your child's care facility to check the hearing and vision of the 3, 4 and 5 year old children.

We will send you the results of this **FREE** screening, along with referral information, if further follow-up is needed.

**Please complete, sign and return this form to your child's care facility to indicate your consent to this FREE Screening.**

Sincerely,

*Donna Thompson*

*Patricia Patten*

*Early Learning Coalition of SWFL*

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent Signature \_\_\_\_\_

Parent Phone - Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

### Vision

### Hearing

<b>Does your child.....</b>	<b>Does your child.....</b>
Have a history of eye/vision problems? Yes No If Yes, describe problem:	Have a history of hearing problems? Yes No If so, what is the problem?
Seem to have trouble looking at things Yes No	Have frequent ear infections? Yes No
Have crossed or misaligned eyes? Yes No	Have an ear infection now? Yes No Right ear Left ear (circle one)
Complain of blurred or double vision? Yes No	Have "tubes" in his/her ears now? Yes No Right ear Left ear (circle one)
Wear glasses? Yes No	
See an eye doctor regularly? Yes No If Yes, name of eye doctor	

