Certificate of Hearing and Vision Screening

Child's Name: _____ DOB: _____

Vision:

Right Eye	Left Eye
20/10	20/10
20/20	20/20
20/30	20/30
20/40	20/40
>20/40	>20/40

◯ Normal vision for age
◯ Your child needs to be further evaluated for vision (please follow-up with pediatrician)

Hearing:

	Right Ear				Left Ear		
	1000Hz	2000Hz	4000Hz		1000Hz	2000Hz	4000Hz
20dB	_____	_____	_____	20dB	_____	_____	_____
25dB	_____	_____	_____	25dB	_____	_____	_____
40dB	_____	_____	_____	40dB	_____	_____	_____

◯ Normal hearing for age
◯ Your child needs to be further evaluated for hearing (please follow-up with pediatrician)

Physician Signature: _____

Printed Name: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Date: _____