HEALTH SERVICES SCREENING RESULTS

Child's Name:_____

Center/HomeBase:_____

Program Year _____

Vision	Date	Evaluated By:	Follow-Up	Screening Tool
Pass Fail			Yes No	**Physical SPOT Suresight Observation**
Pass Fail Refer			Yes No	**Physical SPOT Suresight Observation**
Follow-Up Completed			Yes No	**Glasses ( ) Yes ( ) No**

Notes:

Program Year _____

Hearing	Date	Evaluated By:	Follow-Up	Screening Tool
Pass Fail			Yes No	**OAE Physical Observation**
Pass Fail Refer			Yes No	**OAE Physical Observation**
Follow-Up Completed			Yes No	**Hearing Aides ( ) Yes ( ) No Tubes ( ) Yes ( ) No**

Notes:

HgB	Date	Screening Tool:
		PRONTO Physical Lab
		PRONTO Physical Lab
		PRONTO Physical Lab

Notes: