FDLRS/Crown

www.fdlrscrown.org

VISION AND HEARING SCREENING QUESTIONNAIRE

CHILD'S NAME:_____DOB:_____

DATE:_____GENDER **M / F**

NAME OF PERSON COMPLETING QUESTIONNAIRE_____

VISUAL CONSIDERATIONS:

1.	Can the child follow with his/her eyes a moving target held about ten or twelve inches in front of him/her?.....	YES ☐	NO ☐
2.	When following a moving target with his/her eyes, can he/she easily move his/her eyes past his/her body midline?.....	YES ☐	NO ☐
3.	Does he/she rub his/her eyes frequently except for when tired? ……	YES ☐	NO ☐
4.	Does the child turn his/her head to favor one eye when looking at something? ……	YES ☐	NO ☐
5.	Does the child frequently hold things very close to his/her face to see them? ……...	YES ☐	NO ☐
6.	Are you concerned with his/her vision? ……	YES ☐	NO ☐

If so why? _____

_____

For screener only: VISION: PASS FAIL_____May want to consider follow-up with Pediatrician

HEARING CONSIDERATIONS:

1.	When asking your child to perform a task, does he/she appear to hear you even if he/she are not already looking at you? ……	YES ☐	NO ☐
2.	Does he/she react to loud or unexpected loud noises? (flinch? Or Cover his/her ears?) ……..….	YES ☐	NO ☐
3.	Does the child notice and/or imitate environmental sounds, such as a dog barking or a plane overhead? ……..	YES ☐	NO ☐
4.	Is there a medical history of infections, tubes, wax buildup etc.? ……..	YES ☐	NO ☐
5.	Are you concerned with his/her hearing? ……..	YES ☐	NO ☐

If so why? _____

_____

For screener only: HEARING: PASS FAIL_____May want to consider follow-up with Pediatrician

ADDITIONAL COMMENTS:

_____

_____ _____

Screener Signature/Title Person Completing Form Signature

INFORMATION FOR SCREENING PURPOSES ONLY; NOT TO BE USED AS A DIAGNOSTIC TOOL

Updated:
05/18/20

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