Mississippi Department of Human Services
Division of Youth Services

Hearing & Vision Screening Form

Name: _____	**Allergies**: _____
DOB: _____	_____

Vision Screening Results: Left eye_____ Right eye_____ Both _____

Referral to Optometrist/Ophthalmologist : ☐ Yes ☐ No ☐ N/A Nurse Initials: _____

1st Screening Date: _____

Audiogram	Right Ear *	Left Ear *
1000 Hz (20 dB)		
2000 Hz (20 dB)		
4000 Hz (20 dB)		

☐ **Passed** (Check marks in all of the above boxes)
☐ **Recheck** (Suggested in two weeks)
☐ **Refer to Physician**
Comments: _____
_____
_____
_____
Nurse Signature: _____

2nd Screening Date: _____ **N/A** ☐

Audiogram	Right Ear *	Left Ear *
1000 Hz (20 dB)		
2000 Hz (20 dB)		
4000 Hz (20 dB)		

☐ **Passed** (Check marks in all of the above boxes)
☐ **Refer to Physician**
Comments: _____
_____
_____
_____
_____
Nurse Signature: _____

* Place a (+) mark in the above boxes if the youth raised hand indicating that the sound was heard. Place a (-) mark in the above boxes if the youth did not respond to the sound.

Physician Review: _____ **Date**: _____
Recommendations: _____
_____