

# Mid America Head Start Early Head Start Vision and Hearing Screening Tool

Birth through 3 months: Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent/Guardian: \_\_\_\_\_ Site: \_\_\_\_\_

**Please check or circle all that apply:**

**Hearing**

Parent Report:

Parental perception of hearing:    \_\_\_ Good    \_\_\_ Poor    \_\_\_ Does not know

Family History of hearing problems in childhood: Yes No If yes what? \_\_\_\_\_

Passed Newborn Hearing Screen: Date: \_\_\_/\_\_\_/\_\_\_ Hospital Report    PHP

Awakes to loud noise: Yes No

Observation:

\_\_\_ Observational screening with noisemaker: Bell, Rattle, Other

\_\_\_ Head turns to noise / voice:

Comments: \_\_\_\_\_

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Staff Signature: \_\_\_\_\_ Pass\*    Re-Screen Date: \_\_\_/\_\_\_/\_\_\_ Referral: Yes No

**Vision**

Parent Report:

Parental perception of vision:    \_\_\_ Good    \_\_\_ Poor    \_\_\_ Does not know

Family History of visual problems in childhood: Yes No If yes what? \_\_\_\_\_

Has tears when crying: Yes No

Observation:

\_\_\_ Blinking

\_\_\_ Tracks object held 8 to 12 inches from face; side to side

\_\_\_ Smile when smiled at. (Responsive smile)

Comments: \_\_\_\_\_

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Staff Signature: \_\_\_\_\_ Pass\*    Re-Screen Date: \_\_\_/\_\_\_/\_\_\_ Referral: Yes No

\*Objective notation of the absence of 1 or more of the 'Observation Components' requires a Re-screen in 2 weeks and a referral if not observed on the re-screen date.

The vision and hearing components meet the Mo HealthNet / AAP-Bright Futures minimal requirements for subjective and objective screening of vision and hearing of Birth to 35 months children.

# Mid America Head Start Early Head Start Vision and Hearing Screening Tool

4 to 6 months: Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent/Guardian: \_\_\_\_\_ Site: \_\_\_\_\_

**Please check or circle all that apply:**

Hearing	
<u>Parent Report:</u>	
Parental perception of hearing:    ___ Good    ___ Poor    ___ Does not know	
Family History of hearing problems in childhood: Yes No If yes what? _____	
Awakes to loud noise: Yes No      Head turning with noise: Yes No      Cooing: Yes No	
<u>Observation:</u>	
___ Observational screening with noisemaker: Bell, Rattle, Other	
___ Head turns to noise / voice:	
___ Cooing (Reciprocal vocalizations)	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

Vision	
<u>Parent Report:</u>	
Parental perception of vision:    ___ Good    ___ Poor    ___ Does not know	
Family History of visual problems in childhood: Yes No If yes what? _____	
Has tears when crying: Yes No	
<u>Observation:</u>	
___ Blinking      ___ Tears when crying      ___ Responds to bright colors	
___ Smiles when smiled at. (Responsive smile)      ___ Likes faces      ___ Cover test	
___ Tracks objects side to side      ___ Tracks movement in room      ___ Reaches for objects	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

\*Objective notation of the absence of 1 or more of the 'Observation Components' requires a Re-screen in 2 weeks and a referral if not observed on the re-screen date.

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Form 1040

# Mid America Head Start Early Head Start Vision and Hearing Screening Tool

6 to 9 months: Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent/Guardian: \_\_\_\_\_ Site: \_\_\_\_\_

**Please check or circle all that apply:**

**Hearing**

Parent Report:

Parental perception of hearing:    \_\_\_ Good    \_\_\_ Poor    \_\_\_ Does not know

Family History of hearing problems in childhood: Yes No If yes what? \_\_\_\_\_

Awakes to loud noise: Yes No      Head turning with noise: Yes No      Making sounds: Yes No

Observation:

\_\_\_ Observational screening with noisemaker: Bell, Rattle, Other

\_\_\_ Head turns to noise / voice:    \_\_\_ Responds to sound by making sounds

\_\_\_ Uses voice to express joy and displeasure    \_\_\_ Responds to own name

Comments: \_\_\_\_\_

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Staff Signature: \_\_\_\_\_ Pass\*    Re-Screen Date: \_\_\_/\_\_\_/\_\_\_ Referral: Yes No

**Vision**

Parent Report:

Parental perception of vision:    \_\_\_ Good    \_\_\_ Poor    \_\_\_ Doesn't know

Family History of visual problems in childhood: Yes No If yes what? \_\_\_\_\_

Has tears when crying: Yes No

Observation:

\_\_\_ Blinking    \_\_\_ Responds to bright colors    \_\_\_ Follows objects across midline

\_\_\_ Smiles at image in mirror    \_\_\_ Focuses on people / objects    \_\_\_ Cover test

\_\_\_ Regards hands    \_\_\_ Tracks movement in room    \_\_\_ Reaches for objects

Comments: \_\_\_\_\_

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Staff Signature: \_\_\_\_\_ Pass\*    Re-Screen Date: \_\_\_/\_\_\_/\_\_\_ Referral: Yes No

\*Objective notation of the absence of 1 or more of the 'Observation Components' requires a Re-screen in 2 weeks and a referral if not observed on the re-screen date.

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# Mid America Head Start Early Head Start Vision and Hearing Screening Tool

9 to 12 months: Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent/Guardian: \_\_\_\_\_ Site: \_\_\_\_\_

**Please check or circle all that apply:**

**Hearing**

Parent Report:

Parental perception of hearing: \_\_\_ Good \_\_\_ Poor \_\_\_ Does not know

Family History of hearing problems in childhood: Yes No If yes what? \_\_\_\_\_

Awakes to loud noise: Yes No      Head turning with noise: Yes No      Cooing: Yes No

Observation:

\_\_\_ Observational screening with noisemaker: Bell, Rattle, Other

\_\_\_ Head turns to noise / voice: \_\_\_ Responds to own name \_\_\_ Responds to "No"

\_\_\_ Babbles with inflection \_\_\_ Attempts/ says 'mama / dada' \_\_\_ Begins to gesture Yes / No

Comments: \_\_\_\_\_

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Staff Signature: \_\_\_\_\_ Pass\*      Re-Screen Date: \_\_\_/\_\_\_/\_\_\_ Referral: Yes No

**Vision**

Parent Report:

Parental perception of vision: \_\_\_ Good \_\_\_ Poor \_\_\_ Doesn't know

Family History of visual problems in childhood: Yes No If yes what? \_\_\_\_\_

Observation:

\_\_\_ Blinking \_\_\_ Responds to bright colors \_\_\_ Looks at pages in a book

\_\_\_ Smiles at image in mirror \_\_\_ Focuses on people / objects \_\_\_ Cover test

\_\_\_ Regards hands \_\_\_ Tracks well \_\_\_ Reaches for / picks up small objects, cheerios etc.

Comments: \_\_\_\_\_

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Staff Signature: \_\_\_\_\_ Pass\*      Re-Screen Date: \_\_\_/\_\_\_/\_\_\_ Referral: Yes No

\*Objective notation of the absence of 1 or more of the 'Observation Components' requires a Re-screen in 2 weeks and a referral if not observed on the re-screen date.

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# Mid America Head Start Early Head Start Vision and Hearing Screening Tool

12 to 15 months: Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent/Guardian: \_\_\_\_\_ Site: \_\_\_\_\_

**Please check or circle all that apply:**

Hearing	
<u>Parent Report:</u>	
Parental perception of hearing:    ___ Good    ___ Poor    ___ Does not know	
Family History of hearing problems in childhood: Yes No If yes what? _____	
Frequent ear infections: Yes No    Head injury: Yes No    Says 3 - 5 words Yes No	
<u>Observation:</u>	
___ Observational screening with noisemaker: Bell, Rattle, Other	
___ Head turns to noise    ___ Responds to own name    ___ Responds to: Bye,bye, Peek-a-Boo etc.	
___ Says 'Mama / Dada' plus 1 -3 words    ___ Responds to requests, "Give me the ball", etc. ,	
Gestures: ___ Point    ___ Shakes head    ___ Waves Bye, Bye	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

Vision	
<u>Parent Report:</u>	
Parental perception of vision:    ___ Good    ___ Poor    ___ Doesn't know	
Family History of visual problems in childhood: Yes No If yes what? _____	
<u>Observation:</u>	
___ Blinking    ___ Responds to bright colors    ___ Looks at pages in a book	
___ Smiles at image in mirror    ___ Focuses on people / objects    ___ Cover test	
___ Regards hands    ___ Tracks well    ___ Reaches for / picks up small objects, cheerios etc.	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

\*Objective notation of the absence of 1 or more of the 'Observation Components' requires a Re-screen in 2 weeks and a referral if not observed on the re-screen date.

The vision and hearing components meet the Mo HealthNet / AAP-Bright Futures minimal requirements for subjective and objective screening of vision and hearing of Birth to 35 months children.

# Mid America Head Start Early Head Start Vision and Hearing Screening Tool

15 to 17 months: Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent/Guardian: \_\_\_\_\_ Site: \_\_\_\_\_

**Please check or circle all that apply:**

Hearing	
<u>Parent Report:</u>	
Parental perception of hearing:    ___ Good    ___ Poor    ___ Does not know	
Family History of hearing problems in childhood: Yes No If yes what? _____	
Frequent ear infections: Yes No    Head injury: Yes No    Says 3 - 5 words Yes No	
<u>Observation:</u>	
___ Observational screening with noisemaker: Bell, Rattle, Other	
___ Head turns to noise    ___ Responds to own name    ___ Responds to: Bye,bye, Peek-a-Boo etc.	
___ Says 'Mama / Dada' plus 3 - 4 words    ___ Responds to requests, "Give me the ball", etc. ,	
___ Points to at least one body part    ___ Repeats sounds: Uh-oh, no-no, bye-bye	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

Vision	
<u>Parent Report:</u>	
Parental perception of vision:    ___ Good    ___ Poor    ___ Doesn't know	
Family History of visual problems in childhood: Yes No If yes what? _____	
<u>Observation:</u>	
___ Blinking    ___ Enjoys short books, bright pictures    ___ Cover test	
___ Shows what he wants by pulling, pointing, or grunting    ___ Focuses on people / objects	
___ Feeds self with fingers    ___ Tracks well    ___ Picks up small objects: rocks, blocks	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

\*Objective notation of the absence of 1 or more of the 'Observation Components' requires a Re-screen in 2 weeks and a referral if not observed on the re-screen date.

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# Mid America Head Start Early Head Start Vision and Hearing Screening Tool

18 to 24 months: Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent/Guardian: \_\_\_\_\_ Site: \_\_\_\_\_

**Please check or circle all that apply:**

Hearing	
<u>Parent Report:</u>	
Parental perception of hearing:    ___ Good    ___ Poor    ___ Does not know	
Family History of hearing problems in childhood: Yes No If yes what? _____	
Frequent ear infections: Yes No    Head injury: Yes No    Says 3 - 5 words Yes No	
<u>Observation:</u>	
___ Observational screening with noisemaker: Bell, Rattle, Other	
___ Responds to own name    ___ Responds / repeats words: Bye,bye, Peek-a-Boo , No-no,	
___ Says 'Mama / Dada' plus 3 - 6 words    ___ Responds to requests without gestures: "Sit-down,	
___ Points to and/or names up to 3 body parts    ___ Repeats sounds: Uh-oh, no-no, bye-bye	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

Vision	
<u>Parent Report:</u>	
Parental perception of vision:    ___ Good    ___ Poor    ___ Doesn't know	
Family History of visual problems in childhood: Yes No If yes what? _____	
<u>Observation:</u>	
___ Blinking    Tracks well: ___ less than 1 foot;    ___ more than 6 feet    ___ Cover test	
___ Shows what he wants by pulling, pointing, or grunting    ___ Enjoys short books, bright pictures	
___ Feeds self with fingers    ___ Begins to self feed with a spoon    ___ Stacks 2 -3 blocks	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

\*Objective notation of the absence of 1 or more of the 'Observation Components' requires a Re-screen in 2 weeks and a referral if not observed on the re-screen date.

The vision and hearing components meet the Mo HealthNet / AAP-Bright Futures minimal requirements for subjective and objective screening of vision and hearing of Birth to 35 months children.

# Mid America Head Start Early Head Start Vision and Hearing Screening Tool

24 to 36 months: Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent/Guardian: \_\_\_\_\_ Site: \_\_\_\_\_

**Please check or circle all that apply:**

Hearing	
<u>Parent Report:</u>	
Parental perception of hearing:    ___ Good    ___ Poor    ___ Does not know	
Family History of hearing problems in childhood: Yes No If yes what? _____	
Frequent ear infections: Yes No    Head injury: Yes No    Says more than 10 words Yes No	
<u>Observation:</u>	
___ Observational screening with noisemaker: Bell, Rattle, Other	
___ Says more than 10 words    ___ Begins to use 2 or more words in phrases / sentences	
___ Attempts / Responds to 2 step direction:, "Pick up the ball and throw it to me"	
___ Names 5 or more body parts    ___ Names desired objects: juice, candy, cookie	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

Vision	
<u>Parent Report:</u>	
Parental perception of vision:    ___ Good    ___ Poor    ___ Doesn't know	
Family History of visual problems in childhood: Yes No If yes what? _____	
<u>Observation:</u>	
___ Blinking    Tracks well: ___ less than 1 foot;    ___ more than 6 feet    ___ Cover test	
___ Shows what he wants by pulling, pointing, or grunting    ___ Enjoys short books, bright pictures	
___ Handles spoon well    ___ Stacks 3 or more blocks    ___ Scribbles on paper	
Comments: _____	
_____	
Staff Signature: _____ Pass*    Re-Screen Date: ___/___/___ Referral: Yes No	

\*Objective notation of the absence of 1 or more of the 'Observation Components' requires a Re-screen in 2 weeks and a referral if not observed on the re-screen date.

The vision and hearing components meet the Mo HealthNet / AAP-Bright Futures minimal requirements for subjective and objective screening of vision and hearing of Birth to 35 months children.