



SHEBOYGAN AREA SCHOOL DISTRICT

Hearing and Vision Screening

Vision and hearing screenings in the Sheboygan Area School District will be done on an individual basis. Please be sure to check the students health folder and/or Skyward tab to see if they have already been screened! To refer a student for a hearing or vision screening, the following information will need to be completed and forwarded to Dianna Latsch at ELC. *Please note: Screenings will not be conducted the first 2 weeks and last 2 weeks of the school year.*

Date: _____ Student ID # _____

Student's Name: _____

School: _____ Grade: _____

Staff member making referral: _____

I am requesting the above student be screened for _____
(Hearing/Vision/Both)

Please check the symptoms of **hearing** loss the student is exhibiting:

- _____ I need to raise my voice to get the student's attention
- _____ Student frequently says "huh? or what?" when someone is speaking
- _____ Student has a history of ear infections/earaches/runny ears
- _____ Student turns head toward the sound source or watches the speakers mouth carefully
- _____ Student prefers either very low or very high pitched sounds
- _____ Student talks in a loud or soft voice
- _____ Student turns the radio or television up
- _____ Student does not always come or look when called upon
- _____ Student's speech is poorer than you would expect for a child that age
- _____ Student is inattentive or asks to have words repeated frequently
- _____ Other _____

Results: Right Ear _____ **Left Ear** _____ **Date** _____

Rescreen Results: Right Ear _____ **Left Ear** _____ **Date** _____

Please check the symptoms of a **vision** loss the student is exhibiting:

- _____ Student rubs eyes excessively
- _____ Student is unable to see the board
- _____ Student blinks frequently
- _____ Student holds a book 7" or less
- _____ Student omits letters/words
- _____ Student complains of blurred vision
- _____ Student loses place while reading
- _____ Student complains of headaches
- _____ Student reverses letters (b for d)
- _____ Student fatigues easily
- _____ Student has a short attention span
- _____ Student dislikes or avoids close work
- _____ Student has difficult-to-read hand writing, is crowded or inconsistent in size
- _____ Student squints for either near or far tasks
- _____ Student turns head to use only one eye
- _____ Student covers/closes one eye while reading
- _____ Student moves head back/forth when reading
- _____ Student omits "small" words
- _____ Student complains of double vision
- _____ Student uses a finger to keep place
- _____ Student writes uphill or downhill
- _____ Student skips or rereads words while reading
- _____ Student complains of burning or itching eyes
- _____ Student has difficulty remembering what is read
- _____ Student has poor hand-eye coordination
- _____ Other _____

Results: Right Eye _____ **Left Eye** _____ **Stereopsis** _____