



# SHEBOYGAN AREA

## SCHOOL DISTRICT

### Hearing and Vision Screening Request

Vision screenings for PK, K4, 1st, 3rd & 5th grades will be conducted in the fall of each school year. Additional vision screenings can be requested for elementary students at any time. For middle and high school students, vision concerns will be addressed by automatically sending a vision referral to the parents to consult an eye care provider. Hearing screenings are available upon request for all grade levels on an individual basis. Please be sure to check the Skyward health tab to see if the student has been recently screened, or has any known vision or hearing concerns.. If you would like to refer a student for a screening, please complete the necessary information below and forward it to Dianna Latsch at ELC.

**Important Note:** Screenings will not be conducted during the first or last four 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 speaker's 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 squints for either near or far tasks    |
| _____ Student is unable to see the board                                            | _____ Student turns head to use only one eye          |
| _____ Student blinks frequently                                                     | _____ Student covers/closes one eye while reading     |
| _____ Student holds a book 7" or less                                               | _____ Student moves head back/forth when reading      |
| _____ Student omits letters/words                                                   | _____ Student omits "small" words                     |
| _____ Student complains of blurred vision                                           | _____ Student complains of double vision              |
| _____ Student loses place while reading                                             | _____ Student uses a finger to keep place             |
| _____ Student complains of headaches                                                | _____ Student writes uphill or downhill               |
| _____ Student reverses letters (b for d)                                            | _____ Student skips or rereads words while reading    |
| _____ Student fatigues easily                                                       | _____ Student complains of burning or itching eyes    |
| _____ Student has a short attention span                                            | _____ Student has difficulty remembering what is read |
| _____ Student dislikes or avoids close work                                         | _____ Student has poor hand-eye coordination          |
| _____ Student has difficult-to-read handwriting, is crowded or inconsistent in size |                                                       |
| _____ Other _____                                                                   |                                                       |

**Results: Right Eye** \_\_\_\_\_ **Left Eye** \_\_\_\_\_ **SPOT results** \_\_\_\_\_