NESD HEAD START PROGRAM

WELCH ALLYN HEARING/VISION SCREENING

Child's Name_____ Date of Birth_____

Date_____ Head Start Location _____

Audio Path Hearing Test:

_____ PASS

_____REFER

_____ RESCREEN

Sure Sight Vision Test

_____ PASS

_____ REFER

_____ RESCREEN

COMMENTS _____

_____

_____

Initial ____ 5/08