Privacy Notice (04-14-03) given: ________

LIVINGSTON COUNTY
Health Department
2300 E. Grand River Ave., Suite 102 • Howell, MI 48843-7578 • (517) 546-9850

Screening Location: ______________________ School District: ______________

Child's Legal Name: ______________________ Birthdate: __________ Age: ______

Parent/Guardian's Name: ______________________ Phone Number: ______________

Address: ______________________ City: ______________, MI Zip: ________

Medicaid: (please circle) **Yes** **No** If yes, Dr.'s Name ______________________

(If child has Medicaid, and is 3-6 yrs old results will be forwarded to child's Doctor.)

Dr.'s Address/City ______________________

Dr.'s Phone: ______________________

BRIEF EYE HISTORY

1. Has your child ever been examined by an Eye Doctor: YES NO

   If yes, when? ______________ Name of Eye Doctor: ______________________

   Reason: ____

2. As a parent/guardian, do you have any concerns regarding your child's vision? YES NO

   If yes, please describe: ____

3. When your child is ill or tired, do his/her eyes appear crossed or does one eye wander when looking at an object? YES NO

(If your child confuses colors or a family member has a Color Vision Deficiency, please discuss with your child's doctor. The vision screening performed does not check for Color Vision Deficiency.)

-- PLEASE DO NOT WRITE BELOW THIS LINE --

1. **VISUAL ACUITY – LEA Symbols Cards:**

20/40	Both eyes	0	1	2	3	4	5	6
	Right eye	0	1	2	3	4	5	6
	Left eye	0	1	2	3	4	5	6
20/25	Right eye	0	1	2	3	4	5	6
	Left eye	0	1	2	3	4	5	6

(20/50)
R -
L -

2. **STEREO BUTTERFLY TEST –Near:** PASS FAIL

3. **EYE HISTORY:** PASS FAIL

4. **SYMPTOM REFERRAL:** PASS FAIL

   A N P S W N/A

Rx: Glasses Contacts N/A

VISION SCREENING RESULTS:

___ Pass

___ Refer on: ______________________

____

___ FNR -- Permanent Difficulty

___ Unable to Screen/Complete Screen

Comments: ______________________

____

____

Technician(s): ______________________

____

Date of Screening: ______________________