

LIVINGSTON COUNTY DEPARTMENT OF PUBLIC HEALTH

2300 E. Grand River, Suite 102 • Howell, MI 48843-7578 • (517) 546-9850

Screening Location: _____
 Child's Legal Name: _____ Birthdate: _____ Age: _____
 Child's Nickname: _____ Parent/Guardian's Name: _____
 Address: _____ City: _____, MI Zip: _____
 Phone Number: _____ School District: _____
 Medicaid: (please circle) YES NO If yes, Medicaid # _____

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

PLEASE DO NOT WRITE BELOW THIS LINE

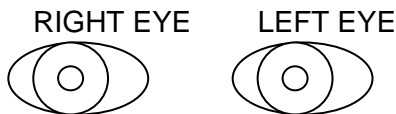
1. VISUAL ACUITY

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

VISION RESULTS:

- ___ Pass
- ___ Refer on: _____
- ___ Under Care
- ___ Permanent Difficulty
- ___ Unable to Complete Screen
- ___ Unable to Screen

2. CORNEAL REFLECTION



PASS DID NOT PASS

3. COVER-UNCOVER TEST – NEAR

Right Eye Movement _____

Left Eye Movement _____

COVER-UNCOVER TEST – FAR

Right Eye Movement _____

Left Eye Movement _____

4. EYE HISTORY

5. SYMPTOM REFERRAL

Comments: _____

Technician(s): _____

Date of Screening: _____