Child’s Name: 

Date of birth: 

Center: 

Session: 

Height: 

Date: 

Weight: 

Date: 

Blood Pressure: 

Date: 

**Hearing Screening (OAE/ERO-SCAN Testing)**

TESTING DATE: ____________

UNTESTABLE_______ REFUSED _______ ABSENT _______

TESTED BY ____________________________ AND ____________________________

(Print first & last name) (Print first & last name)

PASSED __________ REFERRED __________

<table>
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Right Ear

Left Ear

KEY: check mark = pass // “X” = refer

*In order to pass hearing screening, child MUST have a minimum of three check marks for each ear *

**Vision Screening (Vision Plus Optix Testing)**

TESTED BY ____________________________ AND ____________________________

(Print first & last name) (Print first & last name)

PASSED __________ REFERRED __________

REASON FOR REFERRAL: hyperopia (farsighted) / myopia (nearsighted) / astigmatism / other

__________________________  ____________________________

1st Testing DATE 2nd Testing DATE

**ENTERED INTO CHILDPPLUS**

□ NMSU Nursing Student  □ NMSU DACHS Staff

ENTERED INTO CHILDPPLUS

BY: ______________________

DATE: ____________________

OAE/H/ 5.02 5.03 5.04 5.07 7.08 8.09 6.12 8.16 5.17 5.19