DOÑA ANA COUNTY HEAD START: 45-DAY HEALTH SCREENINGS

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_____

FQ	500 (.5)	1000 (1)	2000 (2)	4000 (4)
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 CHILDPLUS
BY:_____
DATE:_____

☐ **NMSU** Nursing Student ☐ **NMSU** DACHS Staff

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